APA GUIDELINES for Assessment and Intervention with Persons with Disabilities

APA TASK FORCE ON GUIDELINES FOR ASSESSMENT AND INTERVENTION WITH PERSONS WITH DISABILITIES

APPROVED BY APA COUNCIL OF REPRESENTATIVES
FEBRUARY 2022

AMERICAN
PSYCHOLOGICAL
ASSOCIATION

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APA Task Force on Guidelines for Assessment and Intervention with Persons with Disabilities

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TABLE OF CONTENTS

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INTRODUCTION

Over 41 million noninstitutionalized Americans are currently living with a disability (American Community Survey, U.S. Census Bureau, 2019). Individuals with disabilities and their advocates have worked for decades 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; Kerkhoff & Hanson, 2015; Krahn, et al., 2015; Priestley, 2001; Switzer, 2008). For a historical summary of events and legislative advancements and setbacks for people with disabilities, the reader is referred to two timelines (PAEC, 2018; National Consortium on Leadership and Disability for Youth, 2007). Advocacy efforts facilitated the passage of the Americans with Disabilities Act (ADA) of 1990 and more recently the ADA Amendments Act of 2008 (ADAAA) that broadened the definitions of "disability," "substantially limits," and "major life activities." Nonetheless, many people with disabilities continue to encounter both blatant and subtle discrimination in employment, housing, education, recreation, child-rearing, and health care, including mental health services (Banks & Kaschak, 2003; Basnett, 2001; Kirschbaum & Olkin, 2002; Krahn, et al., 2015; National Council on Disability, 2012; Raphael, 2006; Schriner, 2001; Smart, 2001; Stapleton et al., 2004; Waldrop & Stern, 2003; Woodcock, Rohan, & Campbell, 2007).

Although many persons with disabilities experience discrimination, each individual responds 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, 2012; Olkin & Taliaferro, 2005; Vash & Crewe, 2004). People with disabilities, like all people, have influences in their lives that contribute to their development and experiences, such as their culture, religion, family of origin, community, education, socio-cultural context, employment, friends, significant others, and co-workers. They are also affected by system-wide factors, such as governmental policies, available programs, and associated funding. Such common influences shape a person's individual disability experience. Above and beyond their *disability* experiences, disabled individuals have their own *life* experiences and, like everyone else, their own personal characteristics, histories, intersecting identities, and life contexts that affect their psychological needs. To work effectively with people who have disabilities, psychologists should strive to become familiar with how disability and related factors influence their clients' psychological well-being and functioning. For example, the disability experience may be influenced by functional capacities, energy levels, pain, age of onset, manner of onset (e.g., military trauma), and whether the disability is static, episodic, or progressive. It is also influenced by one's experience of community. Disabled individuals who have limited contact with other people who have disabilities in their families, at school or work may experience feeling different from others or even ostracized. Individuals with invisible disabilities (e.g., learning disabilities, mental illness, brain injury, chronic pain) may have difficulty convincing others they even have a disability (Smart, 2001; Taylor & Epstein, 1999). Becoming familiar with the experience of living with a disability increases empathy and understanding, and thus enhances assessments and interventions. It is important for psychologists to become aware of how their own attitudes, reactions, conceptions of disability, and possible biases affect their professional relationships with clients who have disabilities. Psychologists can also benefit from learning the best "barrier-free" psychological practices in working with clients with disabilities, including providing reasonable accommodations and appropriately integrating disability-related issues into assessment and intervention.

Unfortunately, while psychologists receive extensive training in how to approach mental health issues, they rarely receive adequate education or training in disability issues (Gibson, 2009; Olkin & Pledger, 2003; Strike, Skovholt, & Hummel, 2004). Few graduate psychology training programs offer disability coursework (Olkin & Pledger, 2003; Weiss, 2010). Limited training and experience may leave many psychologists unprepared to provide professionally and ethically sound services to clients with disabilities. Further, many psychologists seek to develop disability competence after they have completed formal training.

The goal of these *Guidelines for Assessment and Intervention with Persons with Disabilities* is to help psychologists, psychology students, and psychology training programs conceptualize, design, and implement effective, fair, and ethical psychological assessments and interventions with persons with disabilities. The *Guidelines* provide suggestions on ways psychologists may make their practices more accessible and disability sensitive, and how they may enhance their working relationships with clients with disabilities. The *Guidelines* include information on how disability-related factors and sociocultural experiences of disability can impact assessment and intervention. Resources and suggestions are provided throughout the *Guidelines* to facilitate education, training, and experience with disability constructs important for effective psychology practice.

It is hoped that the *Guidelines* increase discussion, training, and awareness about disability across the profession and with other health professionals. It is also hoped that psychology training programs will use these guidelines to consider specific curricular revisions and program modifications that ensure disability issues are addressed and all training opportunities are accessible.

Such interest may additionally contribute to needed research on disability-related issues in assessment (e.g., test construction, norms, use of accommodations) and interventions (e.g., empirically informed activities and programs) as well as enhanced, culturally appropriate communication and decision-making with clients and health care teams.

The *Guidelines* are based on core values in the *Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2017; Smart, 2001). The core values include respect for human dignity and recognition that individuals with disabilities have the right to self-determination, participation in society, and equitable access to the benefits of psychological services. Psychologists recognize their role in facilitating an individual's health and well-being. Additionally, the core values include recognition that people with disabilities are diverse and have unique individual characteristics (like all people), and that disability is not solely a biological characteristic; it is also characterized by the individual's interaction with the physical, psychological, socioeconomic, and political environment. For example, the intersectionality of poverty, disabilities, and multiple minoritized identities (e.g., gender, race, and ethnicity) is well documented (McAlpine & Alang, 2021) and is included in the discussion on intersectional identities in Guideline 7.

Disability is a broad concept that encompasses a wide range of functional limitations and barriers to participation in community life (World Health Organization, 2001). Psychologists are recognized for having a firm grasp on impairments that arise from issues of emotional disturbance and mental health disability. Accordingly, although the APA *Guidelines* apply to persons with all types of disabilities, including mental health issues, disability issues arising from impairments less known to many psychologists, such as mobility, sensory, communication, and neurological impairments, are emphasized. The *Guidelines* also emphasize environmental factors that may influence the experience of disability and that potentially limit assessment validity. Suggestions are included for accommodations that may mitigate these factors.

An extensive literature search was conducted of psychological, medical, rehabilitation, vocational, and educational databases, searching in the areas of disability models, professional relationship and communication issues, attitudes and biases, intersectionality, assessment and intervention across the developmental trajectory, and regulatory and legal resources. The literature reviews were broad in scope, covering both quantitative and qualitative traditions tied to various specialty areas in disability research (e.g., clinical rehabilitation, neuropsychology, rehabilitation psychology, disability studies, education, vocational rehabilitation, forensics). The identified literature represents theoretical, professional, and clinical literature focusing on specific disabilities as well as disability more broadly conceptualized. Along with the original Guidelines, this literature serves as a basis for the guidance offered in this document.

Guidelines are not standards. Standards are generally mandatory and may have an enforcement mechanism. Guidelines are intended to be aspirational and facilitate the profession's continued systematic development and to ensure that psychologists maintain a high level of professional practice. Guidelines are not exhaustive and do 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*.

The *Guidelines* are primarily intended for psychologists and psychology trainees who work in various settings with clients with disabilities. Setting examples include hospitals, rehabilitation and community service settings; outpatient practice; educational, religious, and correctional facilities; employment settings; and business settings addressing legal, insurance, and/or compensation issues. The *Guidelines* are designed 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 with disabilities may seek more extensive disability training consistent with specialized practice. Many avenues exist for psychologists and their students to gain expertise and/or training to facilitate ethical, competent work with individuals who have disabilities. The *Guidelines* are not meant to be prescriptive, but instead offer recommendations on areas of knowledge and clinical skills considered applicable to this work.

Guidelines for Assessment and Intervention with Persons with Disabilities

DISABILITY AWARENESS, TRAINING, ACCESSIBILITY, AND DIVERSITY

GUIDELINE 1

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

Disability as a construct is variously defined based on one's individual beliefs and sociocultural frame of reference. Therefore, the conceptualization of disability and its definition are impacted by legislative and regulatory environments (i.e., public or private entities receiving federal funds). For example, the Social Security Administration's definition of disability is connected to whether or not services and/or funds can be provided to an individual. Further, an individual's adoption of a certain theoretical model of disability may shape the professional's viewpoint or biases about disability. In alignment with Principle D, Justice, of the APA's Ethical Principles (APA, 2017), practitioners should strive to have broad awareness of social and public policy that affects many aspects of psychological services and health care delivery for people with disabilities (Saleh, Bruyère, & Golden, 2019). For example, legal definitions of disability determine who may be eligible for specific services and benefits, and accompanying regulations specify the parameters of providing those goods and services.

Perhaps the most well-known legal example is the Americans with Disabilities Act (ADA) Amendments Act of 2008 (ADA). The ADA defines disability as a "physical or mental impairment that substantially limits a major life activity, or a record of such an impairment, or being regarded as having such impairment" because of an actual or perceived physical or mental impairment (29 CFR Sec. 1630.2). This holds even with the use of equipment designed to mitigate the disability. For example, a person with a hearing impairment that interferes with social interactions would be considered as having a disability even if the use of an augmentative communication device significantly improves the person's ability to engage in conversation. This definition of disability is inclusive of individuals who may have episodic disabilities or chronic illnesses as long as there is a record of such impairment or they are regarded as having such impairment that affects one or more major life activities. Further detail is provided in Guideline 4.

Views on the nature of disability have evolved over time as reflected in the evolution of different theoretical models that define disability. Although current models emphasize an ecological perspective, clients and therapists may hold contrasting beliefs about disability that are influenced by religious, cultural, and medical beliefs. Importantly, psychologists' awareness of these beliefs and how they may affect their clients will facilitate improved clinical processes and outcomes (Altman, 2001; Olkin & Pledger, 2003; Schultz, et al., 2007; Smart & Smart, 2007). Similarly, psychologists, clients, and families may embrace different disability models resulting in specific beliefs and behaviors that may or may not align. It is important for psychologists to understand the potential influence of their own paradigms as well as their clients' in establishing and maintaining a therapeutic relationship and weighing clinical decisions. Several models of disability provided in the literature that have different therapeutic implications are described below.

The *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, 2016; Olkin, 2012). Without realizing it, psychologists and their clients may be affected by these 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 the client believes are dictated by fate.

The scientific models of disability reflect medical, social construction, and functional traditions of conceptualizing disability (Altman, 2001; Chan et al., 2009; Smart & Smart, 2007). The *biomedical model* views disability as a medical problem that deviates from the norm (Gill, et al., 2003). Dokumaci (2019) describes the *medical model* as a linear sequence, that is, pathology to disease to disability. The model emphasizes finding a cure and relieving or eliminating symptoms caused by impairment. The focus is on the person's deficits and elimination of the pathology or restoration of functional capacity. Based on this model, significant treatment advances have been made, particularly in symptom mitigation. On the other hand, its emphasis on cure or amelioration of symptoms may be negatively internalized by some individuals with disabilities to mean something is wrong with themselves, resulting in less effective coping. While many traditional psychological therapies (e.g., behavioral, cognitive-behavioral, and psychodynamic) are grounded in this model to target symptom removal or adjustment to disability, it is important to consider contemporary applications of these interventions in individualized ways that support the specific client and their needs.

Given the *medical model*'s focus on disability and chronic disease and its management, a primary weakness of the model is its omission of social determinants of health. Although psychologists extending the *medical model* may incorporate assessments of function and encourage active patient participation, particularly in treatment decisions, the model still operates based on individual problems that need to be addressed. In this model, assessments are manifestations or indirect expressions of the disabling process itself (i.e., symptom checklists, functional limitations based on injury or chronic disease) (Dokumaci, 2019).

Many disability advocates argue that the *medical model* devalues individuals as "patients." The *medical model* has also been challenged by research demonstrating that physical benefit does not always correlate with the individual's subjective expression of or satisfaction with health. Some rehabilitation research also reflects that with this model participants are defined in terms of their diagnostic groups or, as Elliott and Brenner (2019) describe, their relationship to the medical or rehabilitation setting. These authors argue that a wider lens is needed that incorporates a public health perspective involving the individual and environment. This broadening lens to the person–environment dynamic serves as a clinical underpinning of the *social model* of disability.

In the *social model*, individual impairment no longer defines disability. Rather, disability is a social construct in which the environment, broadly defined as physical and structural barriers as well as societal attitudes, beliefs, and values, either supports or limits one's participation in society and, thus, the experience of disability. 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 to barriers include using universal design to create accessibility for everyone, encouraging 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, 2012; Smart, 2001). In this model, a psychologist may facilitate a client's positive disability identity and self-advocacy skills, and/or consult with others to ensure that the client has opportunities for participation, a voice in decision-making, and adequate accommodations.

The *functional model* of disability (sometimes referred to as the *rehabilitation model*) is pragmatic and cross-diagnostic. It conceptualizes disability as a social consequence of functional capacities and limitations (Chan et al., 2009; Nagi, 1965; Smart, 2001). The model 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 facilitate the client's functional improvement and the development of adaptive strategies that compensate for limitations, given life's demands and supports. According to this model, the person with a disability is perceived to need services from a rehabilitation professional who can provide training, therapy, counseling, or other services to address the deficiencies caused by the disability. Historically, this model gained acceptance after World War II when many veterans with war-related injuries needed compensatory strategies or equipment to enter the civilian workforce. The current vocational rehabilitation system is designed based on this model.

Internationally, the *human rights model* of disability serves as the basis for the United Nations' Convention on the Rights of Persons with Disabilities (UNCRPD). This model views persons with disabilities as rights holders and posits that social structures and policies restricting or ignoring the rights of people with disabilities often lead to discrimination and exclusion. The United States is a signatory to the UNCRPD, but has yet to ratify it (Kanter, 2019). The UNCRPD highlights the importance of effective participation and inclusion in society and advocates for the autonomy and dignity of disabled people. This model is centered on the voice of the disabled and the belief that individuals, such as clinicians, cannot use disability or diagnosis to deny or restrict human rights.

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. The ICF includes assessment of functional domains such as body function and structure, activity and participation, and personal and environmental factors such as access to transportation. In the ICF, impairment is not viewed as a problem but is conceptualized as a difference or change in bodily function or structure; functional limitations become disabling in the interactive context of broader physical, social, and attitudinal factors that restrict participation (Chan et al., 2009; Peterson, 2005; Schultz et al., 2007; WHO, 2001). Psychologists in various specialty areas are translating this model for psychological research and practice (Bruyère & Peterson, 2005; Bruyère, et al., 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). The International Classification of Health Interventions (ICHI) is currently being developed by the World Health Organization to provide a common tool for reporting and analyzing health interventions for statistical purposes (WHO, 2020). For more information about the ICF, readers are referred to the following resource: who.int/standards/classifications/international-classification-of-functioning-disability-and-health.

The *diversity model* of disability (Andrews, 2020; Mackelprang & Salsgiver, 2016) recognizes the inaccessible and often oppressive environments that surround people with impairments. It differs from the social and ICF models in that it situates disability as a unique cultural group because of the experience of impairment, regardless of the individual's environment. This perspective advances the social model in that it recognizes the unique human variations that people with disabilities hold both in their bodies and, subsequently, as part of their identities. The *diversity model* celebrates the experience of disability. In this way, disability is not viewed from a deficit-based perspective; rather, it is viewed as an aspect of uniqueness that contributes to society's overall richness (Connor, 2012; Connor & Gabel, 2010; Erevelles,1996). The *diversity model* expands on the enablement concept and embraces disability identity, which has been described as "a sense of self that includes one's disability and feelings of connection to, or solidarity with, the disability community" (Dunn & Burcaw, 2013, p. 148).

There is growing literature that discusses social and psychosocial identity development for individuals with disabilities (Forber-Pratt & Zape, 2017), as well as the concept of disability identity and disability identity development from an empirical rather than a theoretical viewpoint (Bogart, 2015; Dunn, 2015; Dunn, 2016; Forber-Pratt, Lyew, et al., 2017; Forber-Pratt, et al., 2020). Common themes have emerged that are important considerations for clinical practice, such as the individual's identification as someone with a disability based on personal and social constructs, the importance/perception of self-worth, and the individual's sense of belonging and connectedness with others with disabilities. In addition, the formation and evolution of one's disability identity is viewed as a developmental process. Therefore, the resources needed to maximize engagement change at different time-points. From this frame of reference, psychological service provision considers both (1) the meaning of disability as a personal construct (i.e., within the person's own self-identification), which can intersect with the experience of external factors such as institutional barriers and discrimination, and (2) the timing and readiness of the individual for social connectedness with others with disabilities. Mona, Hayward, and Cameron (2019) specifically mention the use of cognitive behavioral therapy to challenge internalized stigma created by pervasive negative social messages, with the goal being enhanced self-esteem.

Disability identity as a construct is also embedded in the disability culture movement, consistent with a positive affirmation model. That is, disability is not something that needs to be cured, changed, conquered, or "normalized." Disability is incorporated as one facet of a multifaceted human being. In general, the disability identity construct within the disability culture movement reflects positive self-affirmation and pride, and an identification and connection to disability communities as well as advocacy for disability rights. Individuals with disabilities have also called for embracing the actual word "disability" as many within the disability community proudly claim this as an integral part of their identity (Andrews, 2020).

The psychologist's roles in this model focus on facilitating adaptation through encouraging self-exploration, constructive feedback, and the development of social networks. Strategies for demonstrating allyship to and with clients with disabilities require intentional attention, engagement, and openness to consider clients simultaneously as individuals and as members of a powerful, diverse community with a unique identity experience. Disability allyship involves critical self-reflection, potential attitudinal shifts, and social action. Forber-Pratt, Mueller, and Andrews (2019) provide recommendations for engaging in disability identity discussions as well as allyship development for both nondisabled and disabled psychologists.

GUIDELINE 2

Psychologists examine their beliefs and emotional reactions toward various disabilities, determine how these might influence their work, and strive to change ableist practices.

For decades "the attitudes, actions, and decisions of the clinicians working within a health care system have [had] an important impact on disabled people" (Basnett, p. 5, 2001; Olkin, 1999a). Principle D, Justice, of the APA Ethical Principles (2017) advises psychologists to understand their biases and limits of competence through the exploration of feelings and beliefs. In relation to disability, empirical research demonstrates that many misassumptions based on ableist perspectives are made about disabled individuals. For example:

- Disabled people need help even when they do not explicitly ask for it (Dunn, 2019).
- Disabled individuals are asexual or impotent (Azzopardi & Callus, 2015; Lindemann, 2010).
- All disabled people desire improvements in functional abilities or to be "cured" (Hahn & Belt, 2004).
- Disabled people have a lower quality of life than those without disabilities (Iezzoni, et al., 2021).

Ableism is a form of control used either implicitly or explicitly by nondisabled individuals and systems that results in the marginalization of disabled individuals. These negative stereotypes and assumptions experienced by disabled individuals are influenced by embedded structural biases. Negative types of impacts of ableist assumptions are reflected in both historical legal cases and legalized medical procedures (e.g., forced sterilization) as well as in contemporary decisions (e.g., health care plan exclusions; pandemic-related health care rationing) devaluing the lives of people with developmental or acquired impairments (Andrews, et al., 2021; Disability Justice, 2015; Tilley, et al., 2012). The result of acting on implicit biases may lead to microaggressions. Microaggressions are verbal, behavioral, or environmental slights that are the result of an individual's biases. The term was originally developed to describe insults non-Black Americans used toward Black people, and in 2010 this was expanded to include insults toward any marginalized group, including people with disabilities (Sue, 2010).

Conversely, significant positive social change, albeit evolving, has occurred, including successes like the passage of the ADA, the Olmstead Act of 1999 (prohibiting as discriminatory unjustified institutionalization), and the contributions of the Independent Living Movement, borne out of affirmation and advocacy. Understanding this history and ongoing contemporary issues, such as the fight for inclusion in health care plan coverage, access to care (Banks, et al., 2015), and emergency evacuation plans (Taylor, 2018), are critical to recognizing that beliefs and reactions toward people with disabilities are highly consequential. Despite significant progress, lack of understanding, stereotypes, misassumptions regarding quality of life, implicit and explicit bias, and discrimination against people with disabilities persist (Andrews, 2020; Dovidio, Pagotto, & Hebl, 2011; Iezzoni et al., 2021; VanPuymbrouck et al., 2020; White, Jackson, & Gordon, 2006;).

1. One important factor impacting the perception of disability is the health care provider's experience or lack thereof working with individuals with disabilities. A meta-analysis of the relationship between "intergroup contact" and prejudice demonstrated an inverse relationship in which higher levels of contact with people with disabilities correspond with lower levels of prejudice (samples not specific to psychologists) (Pettigrew & Tropp, 2006). Research has also demonstrated that psychologists' and other health professionals' disability-related experience (not just years of experience) correlates with self-reported disability competence and that professional experience with people with disabilities is reported to be an important

factor in successful service provision. This same research found that professionals with less disability-related experience report larger gaps in disability knowledge and skills (Leigh, et al., 2004; Strike et al., 2004). Lack of experience among health care providers may shape implicit bias and lead to erroneous assumptions that are not only counterproductive to the therapeutic relationship, but may result in poor or inadequate decision-making (Basnett, 2001). Erroneous and outdated beliefs about disability may contribute to advice given by professionals that is not rooted in science and has the potential to harm, such as when hearing parents are discouraged from exposing a Deaf child to sign language (Humphries, et al., 2012).

2. A psychologist may 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. As Banks et al. (2015) describe in working with women with disabilities, "biased reactions can affect providers' ability to listen; understand; and provide empathic, respectful care" (p. 166).
3. The field of psychology has a small minority of graduate students and psychologists with disabilities themselves, leaving individuals with disabilities overwhelmingly without access to providers who share the lived experience of disability. The best available estimates indicate that approximately 3% of psychology graduate students and 2% of faculty in APA-accredited programs report having a disability (Andrews & Lund, 2015).
4. 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). This misperception is an example of *diagnostic overshadowing*, that is, over-emphasizing or mistakenly focusing on a client's disability while ignoring other important aspects of one's life, such as life events, capabilities and strengths, and other issues related to the client's presenting concerns (Jopp & Keys, 2001; Kemp & Mallinckrodt, 1996; Mason, 2007; White et al., 1995).
5. Conversely, psychologists may under-emphasize disability-related concerns, or even assume clients use their disabilities as an excuse to avoid specific actions. Psychologists may also experience countertransference based on their vulnerabilities or discomfort with specific physical characteristics, such as scarring, burns, or communication challenges (Artman & Daniels, 2010). Consistent with the APA Ethics Code (Ethical Standard 2.06 Personal Problems and Conflicts), psychologists need to address countertransference issues.
6. Psychologists may assume that people with cognitive impairments or intellectual disabilities are unable to speak on their own behalf; therefore, they are incapable of exercising control over their own lives and are incompetent to make their own treatment-related decisions. Positive assumptions of decision-making capacity are a key factor in affecting supported decision-making (Shogren et al., 2006).
7. Lack of familiarity with disability may influence how a psychologist perceives and responds to the client's emotional expression. Because individuals with disabilities may 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 the client has not adjusted to their disability rather than as an emotional response to painful experiences (Olkin, 1999a; Vash & Crewe, 2004).

Two recommended actions psychologists may take to address biases, faulty assumptions, and negative emotional reactions are (1) self-examination and (2) increasing cultural understanding, including learning about disability-related issues (Banks et al., 2015; Blotzer & Ruth, 1995; Olkin, 2012; Vash & Crewe, 2004; Wilson, 2003). Evaluating and confronting one's biases and the social constructions from which some of these have taken shape is not easy, but the following are practical suggestions related to disability cultural competence in which psychologists may engage.

1. Acknowledge that beliefs, attitudes, and values may be held that differ from the client and may have the potential to be deleterious to rapport building, clinical decision-making, and delivery of clinical services.
2. Examine preconceptions, beliefs, and emotional reactions toward persons with disabilities. Become aware of any implicit biases that contribute to negative views of people with disabilities that may also be compounded by intersections (e.g., Black and disabled; Rynders, 2019; refer to Intersectional Identities - Guideline 7).
3. Consider ableist views that might underpin attitudes and reactions. As Banks et al. (2015) note in working with women with disabilities (WWD), "Self-awareness of one's attitudes is central to working with WWD. People bring a mixture of personal beliefs, attitudes, and/or fears to the idea of the disability experience. Thinking about and working with WWD may threaten concepts a psychologist has held about who she is. Concepts of strength and deficits, independence and dependence, and other attitudinal beliefs need to be explored" (p. 173).
4. The development of attitudes is typically an insidious process. It will take concerted effort and patience to transform one's belief system in a culturally competent manner, of which self-awareness is the first step. Andrews (2020) offers a brief exploration of stigma as well as common myths and stereotypes that are sometimes held by those without disabilities that may serve as a springboard for self-reflection.
5. Consider how disability-related and other life experiences, separately or together, may be related to the client's current psychological issues. Evaluate different intersections of identity with the experience of disability. Dunn and Burcaw (2013) suggest psychologists can challenge unconscious stereotypes and biases through carefully listening to individuals' narratives, with attention paid to psychosocial influences on identity.
6. Assess the client's strengths and weaknesses and incorporate them into interventions. Dunn and Elliott (2005)

suggest that psychologists be aware of the coping versus succumbing frameworks proposed by Wright (1983) and emphasize the client's realistic possibilities rather than limitations in social, vocational, and educational endeavors.

7. Act as an ally to the disability community. Acts of allyship might include taking action to ask the owner to move their vehicle blocking an accessible parking space at the psychologist's practice location, making sure the psychologist's practice's website is Section 508 compliant (e.g., screen reader accessibility, notes about accessible parking and paths of travel, alternative formats of intake forms, etc.) (Forber-Pratt et al., 2019), and working to remove barriers within the broader health care system in which the psychologist practices.
8. Integrate disability-related case material and topics into professional discussions, study groups, courses, and seminars.
9. Contact professionals in the community who can provide consultation and/or supervision; encourage self-reflection and exploration; challenge or provide feedback on beliefs, perceptions, and stereotypes; and provide practical resource information. Professional peers may be an invaluable resource in this exploratory process.
10. Become familiar with disability resources in the community and explore opportunities to strengthen engagement (Forber-Pratt et al., 2019). Resources include local Centers for Independent Living, state assistive technology projects, and advocacy groups.
11. Refer to the current APA Ethics Code (2017) that addresses unfair discrimination, competence, and bases for scientific and professional judgments 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.

Competence to practice is based on a fundamental set of knowledge, skills, and behaviors psychologists demonstrate that facilitate the health and well-being of individuals and groups served. The APA Ethics Code (2017), Standard 2.0, has concretized the importance of maintaining education and training to ensure competent practice. Given the prevalence of catastrophic injury, developmental, and chronic health issues, most psychologists can expect to serve individuals with disabilities, necessitating continuing education and training that may be in relatively unique or less familiar professional development areas. Consider the following non-exhaustive list of examples:

1. Understanding the direct effects of injury or illness and anticipated progression may affect decision-making related to rehabilitation, recovery of function, and community integration, such as anticipated educational and employment needs.
2. A psychologist's competence in disability may affect the fairness and validity of assessments and interventions. Understanding how to appropriately modify assessment tools and procedures and interpret results on non-standardized and standardized tests (e.g., tests that include questions on physical symptoms) may prevent an underestimation of skills. Similarly, being aware of the effects of medications and endurance on cognitive, emotional, and physical presentation may facilitate appropriate interpretation of behavior at both specific time points and over time.
3. A person's resilience is affected by several inter-related factors potentially impacting the disability experience, such as level of cognitive function, energy and endurance, pain, and self-esteem. Understanding the concept of resilience and the importance of assessing resilience in individuals served may impact the creation of appropriate interventions, and hence, overall adjustment over time.
4. As discussed in Guideline 2, it is important to be aware of and manage personal biases and reactions related to disability to build an appropriate therapeutic relationship. This also includes an exploration of cultural differences between psychologist and client. Similarly, whether one explores an individual's experience of marginalization may influence actions recommended. However, it is equally important to remember that disability may or may not be part of the reason an individual is seeking psychological services. Therefore, one must strive to guard against making this assumption or engaging in the spread effect in which disability becomes a primary focus of issues that may be only minimally related to disability.
5. Working with people with disabilities is generally a team-based endeavor. Those historically working in an individual practice setting may need continuing education related to team roles and dynamics within and across professions, such as understanding multiple relationships, setting appropriate team boundaries, addressing team conflict, and supporting team cohesion.
6. Many individuals who have disabilities have formal or informal caregiver supports. Understanding the relevance of these relationships is important because caregiver stress may directly impact how well both the person with a disability and the caregiver(s) adapt over time. For example, psychologists may need to address causal attributions of injury (e.g., blame vs. coincidence) that facilitate or create barriers to healthy relationships. They may also need to address how the personal care assistant and client maintain an equitable relationship. Psychologists may also share relevant resources to promote and support caregiver mental health.
7. There are numerous assistive technology, social, and recreational resources that facilitate community participation for individuals with disabilities (refer to Guideline 11 regarding technology and

the Resource Guide at the end of this document). Being aware of these resources is an important step in translating the individuals' and families' needs and interests into concrete opportunities and actions, particularly related to social and other community engagement.

8. Psychologists are encouraged to learn how to evaluate their own space, communications, and practices to reduce access and performance barriers.
9. To ensure appropriate financial coverage for services needed, psychologists may benefit from learning about different funding possibilities, including billing codes.
10. Many psychologists will first work with individuals with disabilities in either a health care or school setting. Hanson and Kerkhoff (2012) offer a detailed discussion of competence to practice in health care, including achieving baseline competence and developing team-building skills. The reader is also referred to the APA *Guidelines for Psychological Practice in Health Care Delivery Systems* (2013) for a discussion of integrating psychological services in the health care environment.
11. Those serving children will likely have to advocate for appropriate services within the school system, which includes at its most basic level understanding 504 plans and Individualized Education Programs (refer to Guideline 8).

Given professional advances in working with people with disabilities, even highly trained and experienced professionals may need continuing education in areas such as assessment, accommodations, use of technology, therapeutic techniques, and federal and local laws and policies governing disability issues. For example, one might need to understand the difference between a service animal and an emotional support animal before deciding whether to write a support letter for one or the other. Another less frequently occurring, but important, area is preparing court testimony, such as a deposition related to the cause and evolving impact of injury for someone sustaining a traumatic brain or spinal cord injury as the result of a car accident. The competencies defined by the specialties of rehabilitation psychology, clinical neuropsychology, geropsychology, school psychology, and forensic psychology can serve as general guides in identifying potential areas for education and training for those working with individuals with acquired disability. However, there are many resources available to help guide the psychologist's professional development. Continuing education may include Division/State Association workshops; academic disability studies; rehabilitation, educational, and clinical neuropsychology courses and certificate programs; re-specialization programs; post-doctoral fellowships, self-study, and disability-related coursework; work with a mentor; and/or seeking supervision. APA has also published several guidelines and book series relevant to disability education and training. (Examples include *Guidelines for the Evaluation of Dementia and Age-Related Cognitive Aging*, APA Task Force for the Evaluation of Dementia and Age-Related Cognitive Change, 2021; *Guidelines for Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*, 2003; and *APA Handbook of Ethics in Psychology*, Volumes 1 & 2, 2012). Professional journals and organizations publish a wide range of research and practice literature relevant to working with people with disabilities. The following is a non-exhaustive list of suggested national organizations that are specific to disability issues that psychologists may wish to consult to increase knowledge and skills. An extended list of other organizations, many specific to disability subgroups, is provided in the Resource Guide.

- Administration for Community Living: acl.gov
- American Association with People with Disabilities: aapd.com
- Americans with Disabilities Act National Network: adata.org
- Job Accommodation Network: askjan.org
- National Alliance on Mental Illness: nami.org
- National Council on Independent Living: ncil.org
- National Disability Rights Network: ndrn.org
- National Institutes of Health: nih.gov

Finally, a powerful resource for education and training is consultation. Consultation may be especially beneficial when psychologists face challenging or ambiguous ethical situations (e.g., beneficence vs. respect for autonomy reflected in conflicts among family, team, and individual; variable cognition; discharge setting safety; justice reflected in limited resource allocation based on personnel and time available, organizational policy, etc.). In addition to state and national boards, there is a broad network of potential colleagues to assist with specific questions and training needs related to working with individuals and groups of individuals with disabilities. Although one's colleagues are not necessarily within one's own practice or organization, the rise of ZOOM and other networking programs have provided an avenue to more readily reach organizations and individuals needed. In addition to the Committee on Disability Issues in Psychology (CDIP) and the APA Ethics Office, State Psychological Associations commonly offer CE opportunities. They may also sometimes assist with interpretation of state law applicable to psychological practice within a specific state. Another excellent resource are APA divisions. Many colleagues will quickly address specific questions through their listservs. Psychologists who are not members may consider reaching out to a divisional officer listed on the division-specific APA website.

GUIDELINE 4

Psychologists strive to learn about federal and state laws that support and protect the rights of 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 (Pullin, 2002). Three primary federal laws affect individuals with disabilities: the Rehabilitation Act of 1973 (Sections 503, 504, and 508); the Americans with Disabilities Act (ADA) of 1990 plus the Americans with Disabilities Amendments Act of 2008 (ADAAA); and the Individuals with Disabilities Education Act (IDEA) (1997).

Sections 503, 504, and 508 of the Rehabilitation Act 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. Section 503 of the Rehabilitation Act prohibits discrimination against individuals with disabilities in employment and requires employers with federal contracts or subcontracts that exceed $10,000 to take affirmative action to hire, retain, and promote qualified individuals with disabilities. Section 504 of the Rehabilitation Act prohibits discrimination against individuals with disabilities in any federal program or activity. Section 508 requires that electronic and information technology used by the Federal government be accessible to people with disabilities. Sections 503, 504, and 508 do not apply to non-federally funded institutions and do not provide administrative procedures for acquiring accommodations or the due process available under IDEA (Rae et al., 2001).

The ADA and the ADA Amendments Act (ADAAA) of 2008 provide comprehensive civil rights protection to individuals with disabilities. Title I prohibits discrimination in employment based on a disability for qualified individuals who, with or without a reasonable accommodation, can perform the essential functions of a job. Employers are required to provide reasonable accommodations to afford applicants and employees equitable access to the application, retention, and advancement parts of the employment process (USEEOC, 2002). Accommodations are routinely provided to the general workforce, and 95% of workplace accommodation requests come from employees other than those with disabilities, so provisions of accommodations should not pose an undue burden to employers (Von Schrader et al., 2014). For more information about providing accommodations for people with different disabilities at the workplace, refer to the following resource: the Job Accommodation Network at https://askjan.org/.

In 2008, the ADAAA made important changes to the definition of disability, thereby making it easier for an individual seeking protection under the ADA to establish a disability (29 CFR Section 1630.2). Specifically, under the ADAAA, the definition of "major life activities" was expanded to include "major bodily functions." Major life activities include, but are not limited to, "caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working" (42 U.S.C. Section 12102(2)(a)). Major bodily functions include, but are not limited to, "functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions" (42 U.S.C. Section 12102(2)(b)). Therefore, individuals with many more types of disabilities—including those with chronic illnesses such as Crohn's disease, for example—are now legally protected by federal law. For a more complete understanding of the 2008 amendments to the ADA, refer to the following government resource: dol.gov/agencies/ofccp/faqs/americans-with-disabilities-act-amendments.

ADA's Title II prohibits "the exclusion of 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 of the ADA promotes accessibility for "places of public accommodations" (42 U.S.C § 12181- 12189 et seq.), including all private health care providers (42 U.S.C. § 12181(7)(F). The Americans with Disabilities Act Accessibility Guidelines (U.S. Access Board, 2004) specify the standards such entities must meet. The relevant provisions are found in Title III of the ADA and its implementing regulations—refer to Americans with Disabilities Act tit. 3, 42 U.S.C. §§ 12181-12189 (2020); 28 C.F.R. §§ 36.10136.607 (2016). The number of employees associated with the health care provider, its size or status as a non-profit, and the nature of the care or treatment are irrelevant; these factors do not affect the provider's obligation to follow Title III of the ADA.

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 (47 U.S.C. § 201 et seq.). Title V includes miscellaneous provisions, such as the recovery of legal fees for successful proceedings under the ADA. 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. The IDEA is primarily focused on public schools (not private schools); it also applies to charter and magnet schools (refer to https://understood.org/articles/en/individuals-with-disabilities-education-act-idea-what-you-need-to-know). If a student is determined to be eligible for special education services, a team identifies the student's strengths and needs, writes an individualized education program (IEP), develops specially designed instruction, and establishes benchmarks to measure the student's academic and behavioral progress (National Council on Disability, 1996). Decisions on educational modifications and accommodations are based on specific educational needs and performance on multiple measures, including formal and informal testing.

Broad federal legislation designed to protect the civil rights of people with disabilities has been complemented by federal laws designed to offer protections and create opportunities in more specific areas, such as the Voting Accessibility for the Elderly and Handicapped Act of 1984 (Public Law 98-435) and the Ticket to Work and Work Incentives Authorization Act of 1999 (Public Law 106-170). The Workforce Innovation and Opportunity Act (WIOA) (Public Law 113-128, U.S. Dept. Of Labor) that was enacted in 2014 was designed to help individuals access employment, education, training, and support services to succeed in the labor market and to match employers with the skilled workers they need to compete in the global economy. Specifically, Section 188 of the WIOA prohibits discrimination against all individuals in the U.S. based on race, color, religion, sex, national origin, age, disability, political affiliation or belief, and against beneficiaries based on either citizenship/status as a lawfully admitted immigrant authorized to work in the U.S. or by participation in any WIOA Title I financially assisted program or activity. It is important for psychologists to be aware that eligibility for different services by foreign nationals varies, depending on the nature of the service and the related regulatory environment. For example, if employed on a work visa, individuals are protected by the ADA employment provisions. Psychologists are encouraged to consult legal counsel for questions regarding ADA protections and service eligibility.

In addition to federal law, state laws directly affect the rights and protections of persons with disabilities. State law determines the priority for guardianship for individuals with compromised capacity as well as defines the parameters of abuse. Psychologists working with people with disabilities need to be familiar with their specific state's laws related to disability as well as those of other states in which they might provide telehealth services. State laws may provide more protection than federal laws for citizens with disabilities, but never less protection.

There are several resources available to learn about disability rights and legal support services. Two of these resources are *A Guide to Disability Rights Laws* (https://ada.gov/cguide.htm) and *Your Legal Disability Rights* (https://usa.gov/disability-rights). Each state also has a disability rights legal center that provides free legal assistance to people with disabilities who believe their civil rights have been violated or who need assistance with accommodations (https://usa.gov/disability-rights).

Federal laws are enforced by the Department of Justice, which relies on the reports and complaints of individuals with disabilities in order to act. Psychologists may need to consider the intersection of law and policy, 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). Psychologists are encouraged to consult with attorneys and access other legal resources and training to assist with understanding the application of legal mandates to their clients' circumstances and potential roles in advocacy.

GUIDELINE 5

Psychologists strive to provide barrier-free physical and communication environments in which clients with disabilities access psychological services.

Despite the fact that businesses serving the public are required to comply with Title III of the ADA, people with disabilities continue to face both attitudinal and physical barriers that limit access to health care services (Iezzoni, et al., 2021; Lagu, et al., 2013; Mudrick, et al., 2012). The 2019 APA Resolution on Support of Universal Design and Accessibility in Education, Training and Practice (https://apa.org/about/policy/resolution-support-universal-design-accessibility-education.pdf) was based to a significant degree on recognition that (1) these pervasive barriers limiting access to education, assessment, and clinical services contribute to health disparities; (2) efforts to date to address inaccessibility have fallen short; and (3) the application of universal design principles can increase access to products and services that address psychological and other health areas for individuals with diverse needs. Consistent with both the position of APA and the legal requirements of the ADA, psychologists should strive to ensure their practice locations and environments facilitate access for all clients. This includes understanding how therapeutic environments and processes potentially affect therapeutic engagement and working with clients to provide hospitable, accessible environments for both psychological assessment and intervention (Banks & Kaschak, 2003). Several areas are highlighted below to encourage barrier-free physical and communication access, two universal design components referred to in the APA resolution.

PHYSICAL ENVIRONMENTS

Access to physical environments encompasses a broad range of transportation and exterior and interior building and office features, such as those described below.

- Transportation: Clients with disabilities may need accessible transportation services to and from the psychologist's office. An office location with nearby accessible public transportation can enhance service access. However, public transportation may entail effort, time, cost, and navigation of high traffic volume in urban areas. It is therefore helpful for the psychologist to be aware of other accessible transportation options, such as wheelchair-accessible van services and community-based programs that provide transportation services for individuals with physical, emotional, and/or behavioral needs. In addition, transportation resources and associated time to and from the psychologist's office may impact the set-up of the therapy schedule. If clients experience limited endurance, poorly controlled pain, or other disability-related factors affected by travel, a full-length therapy session may prove too exhausting. A mix of in-person and telehealth sessions that remove travel barriers may help clients maintain stamina for individual sessions.

- Building Access: Psychologists using home or office space for in-person appointments are advised to consider multiple components of physical accessibility. Examples include designated parking; pathways to buildings with curb cuts; external and internal doorways wide enough for wheelchair access; doors with automatic openers or easily manipulated handles; use of signage and information posted on websites to help navigate the office space; accessible bathrooms; clearly located ramps and elevators; and barrier-free access to safety exits (McClain, 2000; O'Halloran, Hickson, & Worrall, 2008; U.S. Access Board, 2010). Psychologists are strongly encouraged to evaluate accessibility before renting office space.

- Physical Aspects of the Therapeutic Environment: In addition to general physical access, there are specific environmental factors that can affect level of comfort, engagement, and physical well-being of clients with disabilities during assessment and intervention.

Examples include room temperature for individuals who have difficulty with temperature regulation; lighting matched to the individual's needs (e.g., enhanced lighting for people who rely on vision for orientation or communication; lower lighting for individuals with light sensitivity); chair positioning for individuals with specific postural or skin pressure needs as well as for safety; device positioning while using assessment or treatment tools; removal of scents and odors such as from perfumes and food; and modifications to stimuli (e.g., creating a very quiet environment, reducing visual stimuli via minimizing number or size of objects on walls, desks, and floors). Changing the session structure may also need to be considered for individuals with reduced or variable attention span or ability to process content. Similar to reducing travel time, shorter, more frequent sessions or augmenting in-person sessions with telehealth check-ins may help the client meaningfully engage in assessment and intervention.

Although physical accessibility facilitates service delivery, some adaptations may take time and resources. As an alternative, a psychologist may opt to conduct sessions in a mutually convenient, private, accessible location, or refer the client to a psychologist with similar or greater qualifications whose workspace is more accessible. However, these should be considered last resorts only if physical modifications are cost prohibitive. Psychologists opting to use telehealth services as an alternative or complement to in-person appointments are also encouraged to examine their platforms and digital tools to ensure access for disabled individuals. Ensuring screen reader compatibility when sharing testing stimuli or providing access to closed captioning or Communication Access Realtime Translation (CART) services during the assessment process are two such examples. Communication issues are discussed in more detail below.

COMMUNICATION ENVIRONMENTS

Accessible communication involves the way in which one communicates and the environment in which communication occurs. Assuring appropriate communication reduces the risk of discrimination resulting from inadequate opportunities for clients with disabilities to be involved in their care. It is important to keep in mind that communication access is a two-way process. It is affected by both how clients communicate and the relevant adaptations psychologists and their staff make.

- Diversity in Communication: Clients with communication disabilities may use specific methods or technologies to engage in psychology's services. Clients with speech disabilities may communicate with alternative or augmentative communication such as speech boards, speech synthesizers, or computers. Clients who are Deaf or hard-of-hearing and/or have speech disabilities may call or be called via telephone, or use internet and/or video relay services. Communications' assistants involved in relay services cannot intentionally modify or disclose content, and minimum FCC telecommunications relay service standards require confidentiality (Federal Communications Commission, 2019). Some 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 also be engaged for interpersonal communication. When sign language interpreters are present, the psychologist needs to remember to focus their primary attention and eye contact on the client rather than on the interpreter.

- Communication Content and Processes: Although the psychologist may not manage the type of communication aids and strategies an individual uses during the session, the psychologist does manage content presentation and process variables affecting communication. Word choice, use of verbal and nonverbal messages, and how information is delivered and received may powerfully shape the therapeutic relationship and influence decision-making and outcomes. Accessible communication may be affected by the amount of time the psychologist allots for critical information to be addressed, the level and type of language used, the pace, the psychologist's attitudes, and the environment in which the communication is shared, such as the level of privacy achieved. Examples are provided below.

  - » Psychologists working with individuals with cognitive impairments or whose situations have overwhelmed their coping resources may need to adjust varied aspects of communication. The client may need some or all the following from the psychologist: use of concrete language without metaphor, shorter sentences, increased pausing, calm presentation, consistency in session structure, step-by-step instructions, modeling and repetition, cueing (visual, auditory, and/or kinesthetic) ahead of and/or after task initiation, and checks on therapeutic expectations and actions.
  - » A psychologist may also use cueing with someone with attentional issues, such as saying the name of the client, making eye contact, and then proceeding with calm verbal communication.
  - » A client with a language processing disability may need the psychologist to adjust their listening to the client's rate of speech, ensure clear wording, pause between sentences, and provide written or visual cueing.
  - » A client who uses a visual communication system, speech synthesizer, other specialized approaches, or a sign language interpreter (Olkin, 2012) may need the psychologist to pace questions and comments based on the rate at which the client communicates with the augmentative or other communication supports.
  - » A client with a visual disability may need specific descriptions to enhance awareness of the immediate environment or need documents in large print, as text files, or in Braille (Lighthouse International, 2006; Olkin, 2012).
  - » Clients with diverse linguistic, cognitive, and/or emotional needs may require simplified, easy-to-understand documents, such as office paperwork, and/or have access to aids such as pen and paper, and be given written or taped summaries of

session components (Wehmeyer, Smith, & Palmer, 2004).

 - » It is also important to keep in mind that the consenting process for services may require adaptations to obtain valid consent, consistent with the APA Ethics Code Principles D, Justice, and E, Respect for People's Rights and Dignity and Standards 3.10, 9.03, and 10.01 (2017). These adaptations may include adjusting consent language, including both word type and level/complexity; modifying how the client accesses forms; and involving sign language interpreters and legal guardians (Fisher, 2003). Other detailed recommendations for modifications during intervention are provided by Turner and Bombardier (2019). Please refer to Guideline 14 for a detailed discussion of accommodations related to testing.

- Provider Characteristics: Finally, communication becomes more accessible when the psychologist creates a positive environment. In a small exploratory study focusing on communication with children who were disabled, rapport building, a family-centered approach, and use of communication aids were shown to facilitate communication (Sharkey, et al., 2016). Effective communication is supported by greater knowledge, constructive attitudes, and the overall communication skills of the provider. O'Halloran et al. (2008) found that, among other factors, providers' lack of knowledge about the disability or communication aids and negative attitudes toward people with various communication differences (Deaf, Blind, has aphasia) created significant communication barriers because clients did not feel listened to or able to ask questions. Facilitative strategies included being patient, kind, and restating questions or statements when the first attempt was unsuccessful as well as taking time to learn how specific communication devices work.

Although often unintentional, psychologists send a message regarding the status of individuals with disabilities when they do not invest in universal design that supports communication and physical access to their services. As the Office of Special Education and Rehabilitative Services noted in its 2016 call to action, the "inclusion of individuals with disabilities cannot be an afterthought." The examples provided above highlight a number of straightforward adaptations a psychologist may make to engage effectively and respectfully with disabled clients.

GUIDELINE 6

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

As professional ethics and writing standards dictate, psychologists are expected to strive for "accurate, unbiased communication" (p. 131, Publication Manual of the American Psychological Association, 2020) and must "not knowingly engage in behavior that is harassing or demeaning" (APA Ethics Code, Standard 3.03, p. 6). One critical way to respect the dignity and worth of all people (Principle E of the APA's Ethical Principles, 2017) is to support the use of disability-friendly language. Language may reveal one's attitudes toward people with disabilities (Hauser, et al., 2000). Excessively positive language (e.g., "heroic," "despite his disability," or "overcoming disability") or excessively negative language (e.g., "afflicted with," "suffering from," "confined to wheelchair," or "wheelchair bound") is problematic because these terms reinforce stereotypes rather than focus on the individual (APA Publication Manual, 2020). Additionally, euphemisms (e.g., special needs, handicapable) are equally problematic as they diminish the disability itself and perpetuate the stereotype that disability should be avoided or not talked about (Andrews et al., 2019; APA Publication Manual, 2020). Such language may bias both diagnostic and intervention processes (Simeonsson & Scarborough, 2001).

The use of person-first language (putting the person first, as in person with disability) has been repeatedly endorsed to reduce stigma and bias (Dunn & Andrews, 2015). It literally means that the person comes before the disability. Person-first language is intended to avoid stereotypical or derogatory phrases that imply deficiency or inadequacy (Gill et al., 2003; Khubchandani, 2001; Olkin, 2002). Gernsbacher (2017) stated that person-first language was created as an equalizer intended for use in describing people with and without disabilities. However, the author argues this goal has not been achieved based on reviewing scholarly writing referencing people with disabilities.

Language is not a static concept. It evolves over time as cultural awareness and attitudes shift. This is certainly the case in the evolution of disability language use. Disabled psychologists highlighted the history and evolution of terminology advocating for the use of the word "disability" and promoting the use of identity-first language (Andrews et al., 2019). Consider the example of Rosa's Law when in 2010 the U.S. Congress replaced the term mental retardation with the term intellectual disability. Mental retardation was viewed as stigmatizing, reinforcing negative perceptions of people with intellectual disabilities.

There have been other shifts as well. Specific organizations (e.g., National Federation of the Blind) and many disability rights advocates have argued for the use of identity-first language (i.e., "disabled people") over person-first language. Rather than identity-first language implying something is wrong with the individual, it can be a source of pride; the individual may be empowered by defining their own identity (APA Publication Manual, 2020; Dunn & Andrews, 2015). In addition to identity-first language, some individuals with disabilities have used what traditionally would be viewed as negative terminology (e.g., crip) to refer to themselves or others within their disability subculture (insiders). Others have recently recommended the interchangeable use of person-first and identity-first language (e.g., Research and Training Center on Disability in Rural Communities—RTCDRC).

The shift in thinking about language use is reflected in changes within APA. Although the 6th edition of the Publication Manual of the American Psychological Association (2012) indicated person-first language was preferred, the 7th edition published in 2020 supports the interchangeable use of person-first and identity-first language, like the RTCDRC. Therefore, the following recommendations are offered to psychologists, which are also consistent with APA's Inclusive Language Guidelines (APA, 2021).

- Use the identity-first or person-first language preferred by the client (diabetic person <> person with diabetes; amputee <> person with amputation).
- If the client's wishes are unknown, directly ask the client what language they prefer.
- There are some 'insider terms' that can reflect disability identity or pride (e.g., crip, gimp, quad, para) when used within the disability community by a member of that community. Although psychologists are generally encouraged to align with the client's language, they are discouraged from using this insider terminology in their professional practice.
- Use person-first and identity-first language interchangeably in writing.

Even though one might assume that communication is mostly verbal, most communication is nonverbal (e.g., facial and body language, personal mannerisms, and style) (Burgoon, Guerrero, & Floyd, 2016). If the psychologist is unfamiliar with physical representations of specific disabilities, how a client speaks or moves may be misunderstood (Leigh & Brice, 2003; Wright, 1989). For example, limited movement involved in facial expression caused by facial paralysis may be misinterpreted as flat affect as well as lead to misdiagnosis of psychological issues (Bogart, Briegel, & Cole, 2014). Similarly, facial expressions may be involuntary or have multiple meanings, reflecting such issues as chronic pain, memory problems, or psychological issues. Sign language users convey nuances of meaning through facial expressions. Body language may also 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 also conflict (Wright, 1987), and the psychologist may misinterpret the amount or type of presented emotion and undervalue a client's input.

Overall, the psychologist may facilitate clinical work in a respectful manner by first asking the client about communication preferences, such as asking the client if they would like assistance and requesting specific instructions on the type of assistance rather than assuming the client would accept such assistance. This is consistent with Principle E of the APA Ethics Code, Respect for People's Rights and Dignity. In addition, the psychologist needs to be an effective observer of the verbal and non-verbal information the client provides and be adaptive to this information. For example, in the facial paralysis example above, the psychologist should strive to integrate facial cues with emotional information reflected in other body movements, use of language, and voice cues to increase accuracy of diagnostic impressions (Bogart, Cole, & Briegel, 2014). Respectful behavior by the psychologist involves communication and use of language that are intentional and matched with the particular client's needs. The psychologist is encouraged to seek expert consultation for additional information on appropriate adaptations if needed. Such steps are advised to ensure accurate and respectful representation of the client in determining assessment outcomes and therapy procedures.

GUIDELINE 7

Psychologists strive to recognize the intersectional identities of persons with disabilities.

The term intersectionality means that multiple identities interact in complex ways in individuals' lives. Intersectionality is not the sum of multiple identities; it is the interaction of multiple identities and their relation to power embedded in societal systems of privilege and/or oppression (APA 2021; Crenshaw, 2017). Psychologists will interact with clients who have different kinds of disabilities, impairments, and ways of being represented in the disability community. Psychologists strive to understand their clients' intersections to serve them effectively.

Persons with disabilities hold intersectional identities based on social and cultural identities. APA's *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (2003) and APA's *Handbook of Multicultural Psychology* Volumes 1 and 2 (Leong, et al., 2014) discuss working with clients from diverse cultural and social backgrounds. Psychologists are encouraged to read these as they pertain to the combined identities of their clients with disabilities while recognizing that clients are multidimensional, not simply the sum of these identities.

As noted in Guideline 2, the forces that structurally oppress persons with disabilities are called ableism. As researchers Nario-Redmond, Kemerling, and Silverman (2019) explain, individuals with disabilities experience ableism in many forms, from the seemingly benevolent to more ambivalent or mixed forms (e.g., paternalistic or condescending; jealous/envious) to the blatantly hostile. This may be further complicated when other marginalized identities and oppressive structures are also affecting the individual. Individuals who experience racism, ageism, homophobia, transphobia, religious persecution, or any combination thereof, in addition to ableism, may experience a compounded form of oppression not often considered in designing clinical tools, practices, and therapies. Disparities may result from a complex interaction of socioeconomic and demographic characteristics as well as the intersection of such compounded oppression. In discussing marginalization related to mental health in transgender individuals, Burnes and Chen (2012) point out "when one changes one's authentic self in order to conform to other's perceptions out of fear or stigmatization, distress can arise and negatively affect the individual's mental health" (p. 118).

To work effectively with clients with disabilities, psychologists strive to consider how a client's disability-related issues interact with other cultural and social identities and experiences as well as the potential combined effects of ableism and discrimination on the individual's psychological well-being. Intersectional identities may include race, ethnicity, gender, gender identity, immigration status, socioeconomic background, and other identities that an individual may have as a result of personal characteristics or the context in which they live. Some of these are described below, keeping in mind that these factors may intersect with each other as well as create complex relationships in understanding the individual's potential strengths and experience of disparities.

The American Community Survey data from 2019, which includes self-reported disability, found that within racial and ethnic groups, African Americans and Non-Hispanic Whites have some of the highest percentages of people with disabilities (each group at 14%) followed by Latinos (9%) and Asian Americans (7%) (U.S. Census Bureau, 2019). The percentage of American Indian and Alaska Natives with a disability is very small among the U.S. population at 0.02%. However, within the Alaska Native population, 17.2% have a disability, the highest percentage within racial groups. In 2021, the APA Council of Representatives passed the *Resolution on Harnessing Psychology to Combat Racism: Adopting a Uniform Definition and Understanding, the Role of Psychology and APA in Dismantling Systemic Racism Against People of Color in the U.S., and an Apology to People of Color for APA's Role in Promoting, Perpetuating, and Failing to Challenge Racism, Racial Discrimination, and Human Hierarchy in the U.S.*

Different cultural, religious, and underrepresented groups may attribute different causes and meanings to disability and emphasize different coping strategies. These, in turn, may influence the ways in which disabled persons seek out or respond to psychological services and/or assessment. Belgrave, Gary, and Johnson (2019) offer an excellent discussion of the intersections of culture, race, and disability with clear implications for psychological practice. Although they may not apply to every individual, attributions of blame for disability may be generally relevant in some cultures (e.g., traditional Korean-American culture) but not others (e.g., American Indian, which emphasizes harmony among mind, body, and spirit) (Belgrave et al.). Emphasis in beliefs may also impact coping strategies (e.g., religion among Blacks; family among Hispanics). Similarly, disability-related concepts such as independent living may vary or not apply to different groups (Bryan, 2007; Lomay & Hinkebein, 2006). Recent work has promoted the value of interdependence (Forber-Pratt, 2019; White, et al., 2010). Interdependence does not necessarily mean doing activities on one's own but, rather, having the personal agency and ability to manage one's own care and have one's voice heard during daily living activities to the best of one's ability. Given that 35% of non-institutionalized individuals with disabilities have some type of independent living difficulty (U.S. Census Bureau, 2019), the development of interdependence is a critical area of psychological intervention with particular clients.

One's family structure and culture represent social intersections that may directly affect one's experience of disability and, therefore, willingness or frame of reference to consider specific psychological services and recommendations that foster or deter interdependence. Psychologists working with people with disabilities are advised to explore who is and is not part of the common family structure and who might facilitate or support development of the client's interdependence. For example, does one's culture support participation from those external to this family structure or would reaching beyond the family nucleus be considered taboo (Olkin, 2017)?

Demonstrating a willingness to understand the impact of one's culture on health care values and beliefs may help the psychologist avoid clinical pitfalls and instead identify culturally sensitive approaches as these intersect with the client's identities and needs in support of constructive coping. Further, and sometimes related, having a disability and being an undocumented immigrant may create unique issues in understanding eligibility requirements, access to services, and legal rights (Blakenship & Madson, 2007). Additionally, clients living in multigenerational or mixed-status households may fear jeopardizing their family members' immigration status. For further information, psychologists are referred to the U.S. Immigration and Customs Enforcement (ICE) Family Residential Standard 4.8 entitled: Disability Identification, Assessment and Accommodation (ICE, 2020). It is also recommended that psychologists seek counsel specializing in immigration law and legislation. Even for visa holders or green card holders, navigating the complex systems to receive disability-related services or accommodations can be challenging.

Identification as female also intersects with disability in psychologically relevant ways. There are over 165 million women in the United States, approximately 12.8% of whom have a disability (U.S. Census Bureau, 2019). As the 2018 APA *Guidelines for Psychological Practice with Girls and Women* summarize, girls and women are more likely to face a broad range of stressors with psychological consequences, such as sexual abuse, intimate partner violence, employment discrimination, long-term caregiving expectations, and a barrage of social media images in which idealized physical appearance equates with self-worth. The 2018 *Guidelines* further note that transgender women are at significantly increased risk for suicide, women veterans are more likely to experience PTSD, and older women are more likely to live in poverty. On the positive side, women tend to have more supportive friendships and develop resilience that can help buffer the negative effects of stress. As stated in Guideline 1 from the 2018 APA *Guidelines*, "Psychologists recognize girls' and women's strengths and resilience and work to honor and cultivate these'" (p. 9). However, psychologists also need to strive to recognize the intersections of oppression as noted at the beginning of this section. As Guideline 3 of the 2018 *Guidelines on Girls and Women* states, "Psychologists strive to recognize, understand, and use information about structural discrimination and legacies of oppression that continue to impact the lives and psychological well-being of girls and women" (p. 11).

Women with disabilities report experiencing significant levels of depression and lower self-esteem than women without disabilities (Hughes, Nosek, & Robinson-Whelen, 2007; Niemeier, 2008; Nosek, Howland, et al., 2001), both of which are associated with social isolation, lower quality of intimate relationships, pain, and higher risk of abuse (Nosek et al., 2001). Additionally, women with disabilities face unique experiences and challenges related to dating and parenting (Andrews & Ayers, 2016), such as difficulties with communication about breastfeeding (Andrews et al., 2021). It is important to avoid pathologizing these experiences and to instead offer appropriate psychological services towards recognizing strengths, building resilience and self-esteem, and advocating for and using resources consistent with interdependence. (Refer to Banks et al., 2015 and

Kuemmel, Campbell, & Gray, 2019 for detailed discussions of different intersections for women with disabilities and recommendations for psychological practice.)

Men with disabilities, almost 20 million people or 12.6% of men in the United States (U.S. Census Bureau 2019), also experience important intersections affecting psychological needs. Individuals identifying as men may experience psychological distress from threats to sexual identity and masculinities and concerns about self-reliance, independence, and employment (Marini, 2001). How individuals identifying as men conceptualize their gender role has been shown to impact psychological health. Men who identify with traditional Asian values and masculine gender role expectations and men who embrace Latino gender expectations based on Machismo may experience more gender role conflict and psychological distress (Fu, Shen, & Marquez, 2014), which may be further complicated by traditional perceptions of disability. Nario-Redmond (2010) found that cultural stereotypes of both disabled men and women included dependence, incompetence, and being asexual. Shuttleworth, Wedgwood, and Wilson (2012) offer an ethnographic review of the evolution of thought on the intersection between the concept of masculinity and men with disabilities. They point out that early disability studies focused on the presumed non-synergistic relationship between masculinity and disability (masculine = power, strength; disability = dependency, weakness). Over time, however, this basic conceptualization of masculinity and disability has been replaced with a more complex view, consistent with contemporary representations of disability identity. That is, the experience of disability is multifaceted and layered, impacted by a variety of factors, in particular social structure and interaction. Shuttleworth et al. argue that masculinity is both "dynamic and a context-specific social structure." Rather than conceptualizing the intersection of masculinity and disability as generic, they suggest this intersection is also affected by type, severity, and visibility of disability. Although more research is needed to delineate the impact of these disability specific factors (Kavanagh et al., 2015; Shuttleworth et al.), their findings suggest that psychologists consider exploring nuances to the intersections described on men's psychological well-being. Listening carefully to the individual's descriptions of disability identity can help the psychologist identify important factors for further assessment (e.g., does a visible vs. less visible disability affect the client's perception and social experience of masculinity and sense of self?). Finally, the 2018 APA *Guidelines for Psychological Practice with Boys and Men* note that it is common to use the term masculinities instead of masculinity in recognition of the intersection of multiple identities constructed by social, cultural, and contextual norms. The complexity of disability identity parallels the complex nature of what it means to be masculine. While it may be useful for practitioners to explore whether their clients hold traditional stereotypes as part of their conceptualization of self-worth and meaning (able-bodied = masculine), it is also important to recognize that characterizing masculinity as a disabled person is complex, may include apparent contradictions based on cultural and social norms, and is affected by intersections that may shape and change their sense of self over time.

Gender has historically been represented as binary, which fails to recognize the lived experiences of transgender and nonbinary individuals. In the U.S., the limited research available has consistently shown a high prevalence of disability among transgender people. The National Center for Transgender Equality's 2015 U.S. Transgender Survey (James, et al., 2016) reported that 39% of the nearly 28,000 transgender respondents had one or more disabilities, as compared with 15% of the general population. Disabled adults who are transgender face significant stressors based on intertwined marginalized identities. Like individuals with disabilities, transgender individuals face discrimination and social stigma that negatively impact employment opportunities, availability and quality of health services, risk of bullying and abuse, mental health issues, and overall health outcomes (APA *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 2015; Conron, et al., 2012; Dinwoodie, Greenhill, & Cookson, 2020; Frederiksen-Goldsen, Kim, & Barkan, 2012.; Witten, 2014). Disabled transgender individuals often face homelessness and experience suicidal thoughts and being dismissed by others (Waldman, Perlman & Schwartz, 2018). Similarly, of the 27.1% of people who indicated they had a disability on the Transgender MetLife Survey, 62.1% stated they were under moderate to extreme financial strain (Witten, 2014). Regardless of current disability status, 59% of people surveyed indicated they were moderately to extremely concerned that they would be unable to function independently at some age due to financial insecurity. This overlaps with the fact that both disabled and transgender individuals are often under-employed, less physically active, and receive inadequate health services (Dispenza, Harper, & Harrigan, 2016). In the MetLife Survey, approximately one-third of those with disabilities reported living alone, which may increase concerns about financial stability over time, social isolation, and availability and cost of personal care assistance. Frederiksen-Goldsen et al. (2012) found that disability occurrence was mediated by positive social support and a sense of community belonging as measured by social network size. Similar work has also supported the importance of community among LGBT people with intellectual disabilities (Dinwoodie, et al., 2020). These findings re-emphasize the importance of psychological assessment of health-related financial stress, social support, and facilitation of social connectedness consistent with how clients define their identities. In addition, the research suggests that transgender individuals may hold negative or mixed perceptions of disability, perhaps internalized negative social constructions of disability and sexuality (Dinwoodie, et al., 2020). An affirmative approach to intervention by psychologists may help address these constructions (refer to "Intervention" in these *Guidelines,* particularly Guideline 20). Although survey responses were not categorized by transgender versus non-transgender status, one study's results suggested four components subjectively define health among LGBT individuals: physical wellness, emotional vitality, functionality (e.g., completing daily tasks, working), and social engagement (Dispenza, et al., 2016). The authors suggest that these dimensions offer practitioners a framework for integrating practice across identities for persons with disabilities by exploring barriers and means to strengthen the above relevant components for individual clients.

Gender expression and disability also intersect with sexual orientation, and far more research exists about disabled LGB populations than disabled transgender populations (Andrews & Forber-Pratt, in press). Research shows that the prevalence of disability is higher among lesbian, gay, and bisexual (LGB) adults compared with their heterosexual counterparts. Fredriksen-Goldsen and colleagues (2012) analyzed Washington State Behavioral Risk Factor Surveillance System data ($n = 82{,}531$) and found that approximately 36% of lesbians, 36% of bisexual women, and 25% of heterosexual women were disabled. Approximately 26% of gay men and 40% of bisexual men were disabled compared with 22% of heterosexual men; the likelihood of being disabled for gay and bisexual men was significantly higher than that for heterosexual men, even after controlling for age. Overall, among LGB adults, 36% of women and 30% of men reported being disabled. Additionally, disabled LGB adults were significantly younger than disabled heterosexual adults (Fredriksen-Goldsen, et al., 2012). For further reading, Santinele Martino (2017) outlines scholarship addressing disability and sexuality and calls for more intersectional research. From this work, Santinele Martino also highlights the few researchers who focus on the experiences of disabled asexual individuals (Cuthbert, 2015; Gupta, 2014; Kim, 2011; Lund & Johnson, 2015).

Sexual and gender minority subgroups report significant health concerns related to psychological status (e.g., substance use, mental health issues, including suicidal ideation and victimization; Conron, Mimiaga & Landers, 2010; Lick, Durso, & Johnson, 2013), and these sexual and gender minority subgroups may experience multiple forms of oppression when seeking psychological services. For an individual who identifies as both disabled and LGBTQ, the dual forces of ableism and heterosexism may exist that create challenges for healthy sexual and disability identity development (Lund, Forber-Pratt, & Andrews, 2021). In fact, these individuals may feel pressure to "pick one" aspect of their identity when receiving support (Lightfoot & Williams, 2009). In one study, the decision to disclose sexual orientation for lesbians receiving disability-related health services was impacted by how safe and welcoming they perceived the health care environment. Furthermore, for some women, the acceptance of their partner by the health care team influenced their perception of the health care received (Hunt, Milsom, & Matthews, 2009). In a review of the research literature addressing the intersection of intellectual disabilities and sexual orientation, Wilson et al. (2018) found that respondents risked rejection from each group (ableists and heterosexists), increasing safety concerns and highlighting the need for advocacy and targeted education and support. Children with disabilities must negotiate inter-related components of sexual identity development (e.g., sexual orientation, gender identity, gender expression) within social constructs. These social constructs impact varying levels of parental/familial, peer, and community (e.g., church, school, sports) support and acceptance of LGBTQ expressions. As such, the psychologist should strive to clearly understand these intersections as well as others (e.g., race, economic status). Readers are referred to two important resources in support of affirmative psychological practice: APA's *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* (2015) and APA's *Guidelines for Psychological Practice with Sexual Minority Persons* (2021).

In addition to intrinsic characteristics, external factors, such as where one lives, may affect a client's experience of disability. Living in urban areas may present challenges that provide distinct vulnerabilities for people with disabilities. These may include added difficulties in navigating education, transportation, and health and human service systems, crowded public areas, and heightened risk of violence and crime. Rural Americans have more limited health care access due to workforce shortages, travel distances, and health care costs, which can directly affect disabled individuals, who are disproportionately represented in rural communities (17.1% of rural Americans report having a disability compared with 11.7% of those living in urban areas) (National Association of County & City Health Officials, 2018). Psychologists working in rural areas may serve clients in a wide variety of geographical settings, for which telehealth may provide an avenue to increase service access. Telehealth has been used to train caregivers, address mental health issues, and facilitate basic self-care management for people with disabilities (Christensen & Bezyak, 2020; Zhou & Paramanto, 2019). Limited research further suggests that people with disabilities underutilize telehealth services (e.g., only a small percentage of health care apps are disability focused). However, users view telehealth positively; it saves time and money and contributes to some functional improvement (Christensen & Bezyak). Psychologists' use of telehealth depends on a variety of factors, such as reliable, accessible, and secure technology; allowable interstate practice; specific state billing policies; and appropriate privacy protections (Alonso, et al., 2019; Khubchandani & Thew, 2016). APA's Joint Task Force for the Development of Telepsychology Guidelines for Psychologists (2013) provides helpful suggestions related to decision-making on whether to use telehealth services with disabled individuals. It is important to note, however, that the success of telehealth, including whether it removes health care barriers, has not been well researched (Christensen & Bezyak; Khubchandani & Thew, 2016).

Another significant intersection for people with disabilities is economic insufficiency, given disabled individuals are more likely to live in poverty (Lustig & Strauser, 2007). Twenty-six percent of working-age Americans with disabilities live below the poverty line, compared to 10% of those without disabilities. Poverty also intersects with race. The poverty rate for White Americans without a disability from 2021 U.S. Census data is 9%, while the poverty rate for White Americans with a disability is 24%, and for Black Americans with a disability, 36% (Erickson, 2021).

Disability and poverty are reciprocal—disability increases the risk of poverty, and poverty, associated with decreased access to health care, transportation, and assistive devices, increases the risk of disability. In addition to recognizing the relationship among poverty, disability, race, and psychological issues, psychologists should consider familiarizing themselves with local and regional resources, and partnering with other professionals with resource expertise to effectively assist their clients. Another important resource is the 2019 APA *Guidelines for Psychological Practice for People with Low-Income and Economic Marginalization.*

Across marginalized groups, several fundamental components are suggested for competent psychological practice. These include, but are not limited to, psychologists' consideration of multiple, intertwined intersections impacting well-being; recognition that the formation and evolution of identity may change as the client gains knowledge and resources and their experiences unfold in socioeconomic, cultural, and political contexts; and willingness to explore their own beliefs, biases, and embodiment of cultural stereotypes toward affirmative, respectful practice.

GUIDELINE 8

Psychologists strive to understand the different factors affecting the experience of disability at different developmental stages.

Individuals with disabilities face the same developmental tasks and milestones as everyone else, 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, 2012; Reeve, 2000; Woolfson, 2004). In this section of the *Guidelines*, four major developmental stages will be discussed: childhood, transitioning to adulthood, employment, and older adulthood.

There are over three million children and adolescents with disabilities in the U.S. (U.S. Census Bureau, 2019). When working with children and adolescents with disabilities, psychologists often take a systems approach, including family members, peers, schools, and others. Identification of a disability may occur at different points in development, including around birth. For example, the early identification of deafness has been a goal of the federally mandated Early Hearing Detection and Intervention (EHDI) systems, established in 1999, that operate in all states. Along with newborn screening programs comes the opportunity for psychologists to participate in early assessment and intervention. Psychologists may be called upon to provide an objective assessment of a child's functioning and to support eligibility determination for early intervention services. Psychologists doing this work require familiarity with state guidelines for eligibility and with measures appropriate for young children with various disabilities. Young children may receive supports via an Individualized Family Service Plan (IFSP) that documents and guides the early intervention process provided under Part C of IDEA. The services provided consider the family's resources and child's goals and are intended to support the child's smooth transition from IFSP services to other services under IDEA. Once entering school, many students with disabilities have assessments to develop Individualized Education Programs (IEPs) and participate in psychological, behavioral, and educational interventions. Additionally, some children may receive accommodations in school under Section 504 of the Rehabilitation Act of 1973. Other children with disabilities may not need any type of school-based accommodations (Forber-Pratt et al., 2020). Consequently, psychologists should attempt to understand the developmental needs of children and adolescents with disabilities and combine this understanding with adequate knowledge of how to conduct fair and valid assessments and interventions from developmental, systems, and functional perspectives. It is important to remember that states are required to ensure inclusion of students with disabilities in the educational process, including instruction and assessment. Significant guidance regarding expectations and reporting are provided by the U.S. Department of Education (2018). Psychologists are encouraged to work with school systems and participate on IEP teams to promote inclusion and full accessibility, and emphasize possibilities and opportunities for academic and social development (Olkin,1999a, b).

Like adults, children and adolescents with disabilities hold multiple intersectional identities. Though less is known empirically about these identities, some information is known about the influences of the school's social environment on psychological outcomes. King and colleagues (2018) found that disabled students (as defined by IDEA) and students identifying as LGBQ exhibit higher levels of suicidality and peer victimization, and less school connectedness in comparison with their peers. In fact, students with the highest levels of suicidal ideation were those who identified as disabled and LGBQ (King et al., 2018). Adolescents with disabilities face many challenges common to their typically developing peers (Maxey & Beckert, 2017), including how they develop into sexually expressive and fulfilled adults. Some adolescents with disabilities seem to be participating in sexual relationships without adequate knowledge and skills to help them stay healthy, safe, and satisfied (Murphy & Young, 2005). Support in this process can be a meaningful role for psychologists.

Adolescence is a time of great emotional and psychological change, emerging sexuality, and important life choices about post-secondary education and employment. For some adolescents, it is a time when they are grappling with how to form their disability identity and social relationships with peers with and without disabilities (Forber-Pratt et al., 2021). Like people with disabilities generally, adolescents with disabilities may experience physical and social barriers, reducing their access to the same opportunities and resources as their non-disabled peers. Unfortunately, many existing interventions tend to focus on young children or adults, without specific attention to the needs and interests of adolescents. This can negatively affect opportunities for adolescents to develop essential skills to participate in community. Key factors influencing personal development and socialization often include the attitudes and behaviors of parents, family members, teachers, mentors, and peers, and people in the community and society (Nosek, et al., 2001).

As adolescents with disabilities transition to post-secondary life, some school counselors have been found to be ill-prepared to help them navigate the college search and application process (Alvarez et al., 2020). Students with disabilities commonly face hurdles, such as acquiring accommodations for entrance exams (i.e., SAT, ACT). Students may also be overwhelmed in figuring out how to identify services at potential campuses as there are often different names for centers or services on campuses that provide entrance exam accommodations. Disability status should not play a role in the admissions process; disabled students must meet the same admissions standards as non-disabled students. In fact, disability status is confidential and is not indicated anywhere in students' applications unless they choose to disclose it. However, admission status has no bearing on providing accommodations.

Once in college, disability records are protected by the Family Educational Rights and Privacy Act (FERPA): FERPA applies to all students, including students with disabilities in private or public colleges, and seeks to provide eligible students or parents more control over their educational records. It blocks post-secondary institutions from disclosing "personally identifiable information" (PII) in educational records, including information regarding a student's specific disability, without written permission of the eligible student or parents, unless otherwise mandated by law (https://studentprivacy.ed.gov/faq/which-educational-agencies-or-institutions-does-ferpa-apply). Accordingly, accommodation letters do not include specific diagnoses. Disability service records are *not* considered part of a student's academic record, and disability-related information is not included on a student's transcript.

According to recent data from the National Center for Education Statistics (NCES), during the 2015 to 2016 academic year, 19.4% of undergraduate students and 11.9% of graduate students reported having a disability (NCES, 2019). Additional NCES survey data from Title 4 eligible postsecondary institutions (i.e., eligible for federal financial aid) indicate that the four most commonly occurring disability categories are learning disability, followed by ADHD, mental illness/psychological or psychiatric conditions, and health impairments (Raue & Lewis, 2011). Generally, the legal rights and responsibilities from K-12 to post-secondary schooling are dramatically different. Post-secondary students with disabilities must seek and request accommodations through their disability services office, and students have the responsibility to know what supports they may require and how to find them, whereas in K-12, the school is responsible for identifying accommodations and, quite often, a school psychologist works with an interdisciplinary team to identify disabilities, and then provide reasonable accommodations for student success.

The following table outlines common issues faced by students with disabilities and the primary responsible party for both K-12 and for college.

Many disabled college students struggle with aspects of self-advocacy because of the change in environment and shift in responsibility. The accessibility needs become more complex to navigate because the college environment is more unpredictable and includes more independent aspects of academic life, social life, and general life management. The level of supports for students to receive accommodations at the high school level is different than in the college environment (Hadley, 2011). There is a common trend of students who received accommodations in K-12 school who try college-level courses without needed accommodations as they may be seeking "a 'new beginning' in an educational setting by not having to deal with being labeled" (p. 77, Getzel & Thoma, 2008) or working extra hard to try and succeed academically without accommodations (Lyman et al., 2016). The onus is on the college student to take the initiative and self-advocate for accommodations (Mamboleo et al., 2019). Psychologists are encouraged to advocate and work with disabled clients in high school to set up anticipated needed supports and accommodations from the start of college. Once at a college or university, students will find numerous types of accommodations that may fit their academic needs, such as:

- Priority registration
- Extended time for assignments/exams
- Note-taking assistance
- Faculty-provided written course notes/assignments
- Alternate exam formats
- Test scribe or reader
- Preferential seating
- Permission to record lectures
- Computer access
- Reduced distraction environment
- Reduced course load
- Audiobooks
- Books in large print
- Use of adaptive equipment
- Retroactive withdrawal

ISSUE	K-12	COLLEGE
Identification	School	Student
Assessment	School	Student
Programming	School/Parent	Student/College
Advocacy	School/Parent	Student
Decision Making	Placement Team	Student
Transition Plan	Placement Team	Student

Socially, for many students with disabilities, college is the first time they have a community of others with disabilities to be around and from whom to learn (Minotti et al., 2021). The relationships and connections from this sense of community help students adjust to college life and learn how to navigate accommodations and self-advocate for services. Psychologists may help facilitate healthy social connections.

Psychologists may be a part of the assessment process to (1) administer testing to establish or rule out disability, (2) describe the functional impact of the disability, (3) identify accommodations and make recommendations to address functional impacts, and/or (4) educate others regarding how specific accommodations will increase accessibility. Psychologists may also be in the position to assess (1) how much the student knows about their disability, and (2) the student's ability to self-advocate for needed resources. A few helpful resources that psychologists are encouraged to explore related to supporting clients with disabilities who are transitioning to college are listed here:

- https://www2.ed.gov/about/offices/list/ocr/transitionguide.html
- https://accessiblecollege.com/
- https://aplaceforusdisability.org/

Transition is a complex and multifaceted process in which the individual gradually moves from a child being cared for to an autonomous young adult (Beghi et al., 2014; Borlot et al., 2014) who is expected to integrate into society and become independent (Khan et al., 2013). The challenges associated with this transition are magnified for youth with disabilities as it involves multiple concurrent changes, including the disability itself and potential cognitive, behavioral, or psychological issues that affect age-specific development. As of the 2019–2020 school year, 7.3 million children in the United States ages 3 to 21 received special education services through IDEA (National Center for Education Statistics, 2021). This number constitutes 14% of the total number of all students receiving public education (NCES, 2021), indicating the need for efficient, effective, and collaborative efforts to support students with disabilities during times of transition.

While the roles of professionals in the transition planning process will vary according to their expertise and the amount of time each devotes to the process, psychologists will likely need to coordinate their assessments and continuation of services. Several other stakeholders may be involved in helping students with disabilities during college. In addition to individuals with disabilities, their families, and school personnel, state vocational rehabilitation agencies, developmental disability agencies, and mental health and social service agencies may be part of a disabled student's support system. Throughout the transition process, psychologists are usually charged to conduct psychoeducational assessments, explain assessment results, and make recommendations to the transition team based on that assessment; assist in gathering additional information relevant to a student's cognitive, academic, and interpersonal skills; and provide interventions for students who experience mental health issues. Psychologists are encouraged to carefully monitor for the emergence of learning, vocational, and social needs (e.g., academic achievement, employment) facing children and adolescents with disabilities as the challenges may persist into adulthood.

Unfortunately, current transition services beyond academics do not often reflect the lifelong needs of youth with disabilities because the services may be diagnosis driven and relatively static. A few domains that deserve particular attention in a continuous, coordinated manner include psychosocial functions (e.g., emotional function, participation in education and employment), environmental factors (e.g., social support, stigma, peer acceptance), and personal factors (e.g., autonomy, self-concept, self-esteem, coping strategies, and adaptive behavior).

Comprehensive transition assessment helps facilitate a seamless and smooth transition. When psychologists plan assessments for youth with disabilities, they are encouraged to consider a holistic, biopsychosocial approach, especially to better identify, analyze, categorize, and address risk, protective factors, and outcomes. While neuropsychological assessment is beneficial for understanding cognition, (e.g., memory, executive processes; Fraser et al., 2010), functioning relevant to academic, social, and vocational activities, and determinants of quality work participation also involve an understanding of personal and environmental factors (Smeets et al., 2007).

Given the person–environment perspective, adopting a comprehensive holistic framework (e.g., the ICF) that reflects the dynamic and diverse needs of people with disabilities over the life span will help guide developmentally appropriate assessment and enhance transdisciplinary collaborative processes among all stakeholders to better inform transition planning, interventions, and service delivery. Studies have highlighted the promising applicability of the ICF as a conceptual framework to guide transition processes for young people with disabilities, including learning disabilities (King et al., 2005) and intellectual disabilities (Foley et al., 2012).

The next developmental step is employment. All people should have an opportunity to work, as work provides individuals with a sense of purpose, self-worth, and financial and economic independence. Yet people with disabilities are half as likely to be employed than their non-disabled peers; 38% of working age Americans with disabilities are in the labor force compared with 76% of those without disabilities (Erickson, Lee, & von Schrader, 2021). This results in higher levels of poverty and lower annual household income rates (Erickson, Lee, & von Schrader, 2021). People with disabilities have lower median annual household incomes too: $46,900 for a U.S. household with a person with a disability compared with $74,400 for those without a person with a disability (Erickson, Lee, & von Schrader, 2021). Most working-age people with disabilities want to work. While persistent stigmas remain an obstacle, evidence shows that individuals with disabilities, such as physical, cognitive, or intellectual disabilities, can be highly successful workers (Kessler Foundation, 2015; National Association of County Behavioral Health and Developmental Disability Directors, 2018; Padkapayeva et al., 2017).

Employment disability discrimination may occur at any point in the employment process, from hiring through termination. Data from the U.S. Equal Employment Opportunity Commission (EEOC), the enforcement agency for the employment provisions of the Americans with Disabilities Act of 1990 as amended (ADA), show that alleged unlawful discharge is the most common employment disability discrimination claim filed by individuals with disabilities (U.S. EEOC, 2020). Thus, when advising people about the return-to-work process, psychologists strive to be aware that clients may need coaching about possible discrimination risks when returning to the workplace and their rights in requesting accommodations under the ADA (U.S. EEOC, 2002). The ADA employment provisions (Title I) require an employer to provide reasonable accommodations to qualified individuals with disabilities who are eligible to become employees or applicants for employment, unless to do so would cause "undue hardship" to the employer. Generally, an accommodation is any change in the work environment or in the way things are customarily done that enables an individual with a disability to enjoy the same employment opportunities as individuals without disabilities. (U.S. EEOC, 2002).

Another development area for psychologists to be aware of related to disability is the aging process. Of the 41 million people with disabilities in the non-institutionalized U.S. population, 43% are 65 years of age or older (U.S. Census Bureau, 2019). Given the growth of the older adult population, there is increased likelihood that psychologists will encounter older adults in their professional roles. Even pediatric psychologists may encounter older adults as the number of grandparents providing childcare increases. There are more than 2.7 million American children being raised within homes of kin and grandparent caregivers (U.S. Census Bureau, 2019). Although the prevalence of disability has decreased within the older adult population due to improved health care (Mather, Jacobsen, & Pollard, 2015), older adults are still more likely than younger people to experience disability because the prevalence of disability increases with age (Freedman et al., 2014; Verbrugge, Latham & Clarke, 2017). The number of physical co-morbidities in older adults tends to be additive (Bleijenberg et al., 2017; Stenholm et al., 2015). (Refer the APA *Guidelines for Psychological Practice with Older Adults*, 2014, for a review of issues potentially affecting functional capacity.) The experience of disability and associated resources in older adults also interact with when the disability occurred and the type of disability experienced (for example, people with spinal cord injury have been shown to have less income than people with multiple sclerosis; people aging with sensory and visual difficulties may experience reduced social activities over time; disabilities impacting activities of daily living predict decreased independence and poorer outcomes) (Bleijenberg et al., 2017; Desrosiers et al., 2009; Dreer & Cox, 2019; Jensen et al., 2014; Turcotte et al., 2015; Verbrugge, et. al., 2017). Persistent disability is more likely to occur in older adults who are women, from a marginalized group (e.g., Blacks, Hispanics, transgender individuals) or those with less education and income, often due to co-morbidities created by social and economic disadvantages (Frederiksen-Goldsen et al., 2013; Jensen et al., 2014; Verbrugge et al., 2017). Women (75 years and older) are twice as likely as men to live in poverty and are more likely to live alone (Mather et al., 2015). Furthermore, by 2060 almost half of those 65 years and older will be racial/ethnic minorities. All these factors illustrate that attending to aging with disabilities will be an increasingly significant public health area psychologists are likely to address through clinical services and collaboration with other providers contributing to comprehensive health management.

Despite how an individual has acquired a disability, there are numerous common correlates with shortened life spans or increased morbidity for older adults with disabilities. These include lack of (1) continuing employment and financial strain (Szanton et al., 2008; Rohwedder & Willis, 2010), (2) social support and environmental access (Clarke et al., 2021; Jensen et al., 2014), (3) physical activity (Mather, et al., 2015), and (4) pain management (Cruz-Almeida et al., 2019; Li, Tse, & Tang, 2020). Related, there are additional transitions or potential transitions that arise for individuals as they age. These may require assessing or reassessing person and environment fit based on changing support needs. Despite challenges that may occur with aging, focusing on living in the community with appropriate supports as opposed to institutions or nursing homes is known as aging in place. Benefits of maintaining home residence include reduced cost, preservation of social connections, increased personal independence, and familiarity with surroundings (Clarke et al., 2021). However, aging in place may be complex and challenging depending on the situation, and may be a source of stress and/or discussion between older clients and/or family members and psychologists. Certain life changes that can be related to aging such as loss of income or widowhood may make it difficult to have a supportive environment to maintain aging in place (Clarke et al., 2021; Fuller-Thomson et al., 2009). Older disabled adults often lack qualified providers and adequate community services (Wacker & Roberts, 2008), partially because disability may be erroneously conceived as an inevitable aspect of aging, thus not requiring intervention. The reader is referred to the APA *Guidelines for Psychological Practice with Older Adults* (Guideline 2, 2014) for other common stereotypes about aging.

In addition to positivity, there are several protective factors, including economic resources and social and behavioral actions, that correlate with positive aging with disabilities, disability management self-efficacy, and overall health (Alschuler et al., 2018; Amtmann et al., 2019; Dreer & Cox, 2019; Freedman et al., 2014; Office of Disease Prevention and Health Promotion. 2021; Jeste et al., 2013; Mather et al., 2015; Terrill, 2016; Weintraub & Ashley, 2010). Psychologists may play a key role in facilitating the development and maintenance of several of these. Examples include:

- addressing quality and type of social supports, evolving personal care assistant needs, and participation in social roles;
- providing education and reinforcing reliance on acquired knowledge;
- working with clients to establish goals and routines, including healthy nutritional and sleep patterns;
- matching cognitive demands to cognitive abilities;
- facilitating pain and fatigue management;
- building resilience; and

- encouraging physical activity.

An objective of the Healthy People 2030 (Office of Disease Prevention and Health Promotion, 2021) is to increase the proportion of older adults with disabilities who get physical activity because those who are not physically active are more prone to falls and cognitive decline, and physical activity corresponds with psychological well-being (Avis et al., 2021). Along with other team members, such as the occupational therapist, the psychologist may discuss the availability, costs, and benefits of using applicable assistive devices and technology, and making environmental modifications to maintain activity and independence. As Bombadier et al. (2010) point out, "the modal response to disability and aging is not depression but resilience" (p. 292). Psychologists with appropriate training may help those getting older with a disability incorporate activities into their routine that support continued resilience and adjustment.

GUIDELINE 9

Psychologists strive to recognize the strengths and challenges of families of individuals with disabilities.

Families may have varied reactions when learning their loved one has a disability, from feeling overwhelmed and anxious to feeling validated and relieved because their diagnostic questions have been answered, such as autism spectrum conditions (Robinson, et al., 2015; Rotondi et al., 2007). Family members also typically take on additional roles as part of the social network of people with disabilities. Almost 18 million people in the U.S. serve as caregivers for older adults with health or functional limitations (Schulz, et al., 2016). Family members commonly become caregivers or personal care assistants, addressing self-care needs; providing transportation; keeping medical and therapy appointments that often result in lost work hours; researching a family member's disability; advocating for health, school, vocational, and community services; serving as surrogate decision makers; and often bearing extra financial burdens (Elliott, Berry, & Grant, 2009; Kuo et al., 2011; Rivera, 2012; Schulz et al., 2016). They are sometimes thrust into a medical world that can be fragmented, overwhelming to navigate, and costly. Along with these roles and stressors, family members may feel frustrated, angry, confused, exhausted, and sad (Brickell, et al., 2020; Robinson et al., 2015; Rolland & Walsh, 2006; Schulz, et al., 2016). Sometimes their support may be viewed as unhelpful (e.g., minimizing injury, giving unwanted advice) (Fong et al., 2006), because many families feel unprepared, inadequately trained, and lack formal support for these roles. Yet positive support, in general, has been shown to contribute to reduced morbidity and mortality and improved resilience of individuals with disabilities, and caregiver and personal care assistant contributions may be vital to the well-being of individuals with disabilities (Chronister et al., 2009; Lustig, 2002; Reblin & Uchino, 2008; Robinson et al., 2015; Rotondi et al., 2007; Wongvatunyu & Porter, 2008). Recognizing these important contributions, the U.S. Congress in 2018 passed the RAISE (Recognize, Assist, Include, Support and Engage) Family Caregivers Act for the U.S. Department of Health and Human Service (HHS) to develop a strategy to better support unpaid caregivers, including care assistants for individuals with disabilities.

Family functioning, caregiving demands, and everyday (non-clinical) behavioral challenges in individuals with specific developmental and acquired disabilities have been shown to directly affect overall familial caregiver stress and health (Brickell et al., 2020; Lach et al., 2009; Rania et al., 2005; Robinson et al., 2015; Rotondi et al., 2007; Pendergrass et al., 2017; Schulz et al., 2016). In some cases, these family dynamics and stressors may rise to the level of disability-related abuse (discussed in Guideline 10). Self-esteem and time spent providing care have been shown to be inversely linked to well-being (Cantwell, Muldoon, & Gallagher, 2015; Hart et al., 2007). Furthermore, families of individuals with disabilities may cope with stigma by association, negative perceptions, and misassumptions and blame by others (Andrews, 2020; Kinnear et al., 2016; Lalvani, 2015; Neely-Barnes et al., 2011; Robinson et al., 2015; van der Sanden et al., 2013; Werner & Shulman, 2015). In one study, teachers believed that the lives of parents of children with disabilities were characterized by long-term grief and loss and defined by their child's disability, beliefs the parents did not share. Although sometimes parents internalize public perceptions (Kinnear et al., 2016), they are more likely to frame their experiences in a sociocultural context creating the need for strong advocacy (working against dominant cultural stereotypes) (Lalvani, 2015). In fact, Scorgie et al. (2004) theorize that positive transformation may result from intentional choices to transcend stereotypical images and meanings parents (and other caregivers) confront across time.

Despite the challenges families face, they also experience many positive changes as the result of having a family member with a disability, especially as they learn more about disability over time and adjust to new roles. Examples of such positive changes include strengthening family bonds, achieving new social networks, gaining confidence, increasing sensitivity to disenfranchised groups, and gaining greater appreciation for life (National Council on Disability, 2012; Robinson et al., 2015; Schulz et al., 2016; Scorgie et al., 2004; Wongvatunyu & Porter, 2008). The limited research on siblings of individuals with disabilities is somewhat mixed, suggesting that most siblings adapt well, although some are at risk for emotional and behavioral issues, which are likely mediated by family function and/or financial status (Giallo et al., 2012; Giallo & Gavidia-Payne, 2006; Marquis, Hayes, & McGrail, 2019; Neely-Barnes & Graff, 2011).

Generally, family members experience quality family life by realigning their priorities, balancing the needs of all family members, accessing resources, and deciding what is important in life (Goodley & Tregaskis, 2006; Rosenthal et al., 2009; Wilgosh, Nota, Scorgie, & Soresi, 2004; Wilgosh & Scorgie, 2006). For many families, disability may 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, & Sobsey, 2004). In addition, stress management and a sense of mastery regarding caregiving have been shown to positively influence psychological health (Rania et al., 2005)

Like everyone else, individuals with disabilities get married and have families. These changes create new opportunities and challenges, some of which may limit full participation in family life if not addressed. Ableist assumptions that desexualize people with disabilities contribute to the myth that disabled individuals do not have intimate relationships or do not marry. Evidence suggests people with disabilities marry at a lower rate, and for those between the ages of 30 and 59, marry later than those without disabilities (Clarke & McKay, 2014; Tumin, 2016). This trend may in part be because of more limited social opportunities to initiate intimate relationships and lack of sex education (Andrews, 2020; Santinele Martino, 2017). LGBTQ individuals with disabilities have fewer role models and fewer comfortable spaces to explore their sexuality (Santinele Martino, 2017). One small study also suggests that internalized stigma as well as a partner's respect for disability-related concerns play a role in relationship adjustment for sexual minorities with disabilities (Dispenza et al., 2021).

Even though some adults with disabilities face competency and guardianship issues, the vast majority of adults with disabilities have the rights and capacity to engage in sexual intimacy, partnership, and marriage and family (O'Toole & Doe, 2002; Shuttleworth & Mona, 2020). The National Center for Parents with Disabilities indicates there are over 4 million parents with disabilities with children under the age of 18. Parental training has been shown to have positive effects for parents with insufficient parenting skills (Andrews & Ayers, 2016; National Council on Disability, 2012). Disability is not an independent predictor of problems children struggle with (National Council on Disability, 2012). Nevertheless, parents with disabilities fight against institutional policies and social and research biases and assumptions, including among health professionals, that they are unfit to parent and will have poorly adjusted children (Andrews & Ayers, 2016; Bergeron et al., 2012; Frederick, 2015; National Council on Disability, 2012; Olkin et al., 2006). Disabled parents also face barriers accessing healthcare before, during, and after pregnancy (Frederick, 2015; Powell, Andrews, & Ayers, 2021). Parents with disabilities may also fear that any misbehavior by their children will erroneously be attributed to their disability as confirmation of poor parenting, and that they risk removal of the child from the home, which is not unfounded (Andrews, 2020; National Council on Disability, 2012). Titles II and III of the ADA are designed to protect the rights of individuals with disabilities who become parents and those who want to adopt through public or private agencies (National Council on Disability, 2015). Despite these laws, disability is used to unfairly exclude prospective adoptive parents, and children are removed from parents with disabilities at a higher rate than for non-disabled parents simply based on disability status without evidence of harm (National Council on Disability, 2015). Parents with disabilities are further disadvantaged by inaccessible places, inadequate services, and lack of insurance coverage for adaptive equipment, limiting full participation and necessitating creative problem solving on their part (Andrews & Ayers, 2016; Bergeron et al., 2012).

Disability may not be a salient factor when the family of a disabled individual seeks psychological services. However, psychologists are encouraged, when appropriate, to include families in assessments and interventions to help them manage stress, develop resilience, enhance quality of family life, and resolve feelings or family conflicts about disability (Bailey et al., 2006; Ehrmann & Herbert, 2005; Power & Dell Orto, 2004; Rivera, 2012; Rosenthal et al., 2009; Scorgie et al., 2004; Turnbull & Turnbull, 2001; Wilgosh et al., 2004). Caregivers not exhibiting resilience or positive social support may experience initial psychological distress, indicating needed psychological intervention (Elliott et al., 2014). The resiliency model of family stress, adjustment, and adaptation (Kosciulek, McCubbin, & McCubbin, 1993; Lustig, 2002; 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.

Disability may lead to a redefinition of family roles and expectations. Health care professionals may directly affect family mental health based on a constructive presentation of the disability and by listening closely to the family's initial concerns that, in turn, will help reduce the common family experience of feeling unsupported or overwhelmed by the health care system. The psychologist's provision of information and resources will also change over time as families adapt to their personal and environmental circumstances and engage in multiple systems (e.g., family dynamic, academic/vocational, interpersonal relationships). Psychologists strive to recognize the unique needs of each family based on that family's sociocultural background to help reduce barriers and facilitate family adjustment.

Facilitating positive problem-solving skills and developing resilience, social support, and self-esteem may strengthen family functioning (Elliott et al., 2014; Kurylo, Elliott, & Shewchuk, 2001). Teaching family members self-advocacy skills may also empower them to acquire resources or create change within stigmatizing or inaccessible environments (for example, a school psychologist helping parents of a child with a specific learning challenges advocate for educational needs).

GUIDELINE 10

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

There is no single comprehensive source for data about abuse and violence against people with disabilities, and research criteria and quality vary significantly (Bowen & Swift, 2019; Hughes, Bellis, Jones, et al., 2012; Jones, Bellis, Hughes, et al., 2012). However, data across studies indicate that abuse is perpetrated against people with disabilities at significantly higher rates than those without disabilities (Alriksson-Schmidt, Armour, & Thibadeau, 2010; Emerson & Roulstone, 2014; Fisher et al., 2016; Harrell, 2017; Hughes et al., 2012; Jones et al., 2012). This abuse includes sexual, physical, emotional, financial, and disability-specific abuse (Curry et al., 2011; Emerson & Roulstone, 2014; Saxton et al., 2006). Abuse may be the initial cause of a disability or may exacerbate existing disabilities. Examples of disability abuse include withholding items fulfilling basic needs (food, hygiene items); withholding or administering too much medication; withholding or dismantling adaptive equipment (e.g., wheelchairs; communication devices); preventing health care appointments; and confining someone involuntarily and/or leaving them in a dangerous situation (Chang et al., 2003; Hughes, 2005; Lightfoot & Williams, 2009; Nosek, Foley, Hughes, & Howland, 2001; Oschwald et al., 2009; Plummer & Findley, 2012; Powers et al., 2008; Saxton et al., 2001). Lund (2020) reviews unique risk factors for and types of disability-related abuse heightened by the COVID-19 pandemic. Psychologists are also encouraged to review Taylor's work (2018), who provides a history of litigation against governmental and other agencies who failed to address appropriate emergency/disaster evacuation, shelter, and communication plans for individuals with disabilities. He cites several resources on emergency planning that can help avoid placing individuals with disabilities at risk of harm.

The latest five-year aggregated data from the U.S. Department of Justice (Harrell, 2017) for violent crime (rape, sexual assault, robbery, aggravated assault, and simple assault) show the following:

- People with disabilities experience violence perpetrated against them at 2.5 times the rate of people without disabilities (32.3 per 1000 compared with 12.7 per 1000); rape and sexual assault are over 3 times the rate (2.1 versus 0.6 per 1000).
- 12- to 15-year-olds with disabilities have the highest rate of violence perpetrated against them (144.1 per 1000, compared with 38.8 per 1000 people for those without disabilities).
- People with disabilities of two or more races have the highest rate of violence perpetrated against them (128.5 per 1000 for multiracial people with disabilities compared with 33.6 for multiracial people without disabilities).
- People with cognitive disabilities have the highest rate of violence perpetrated against them (57.9 per 1000) compared with those with other types of disabilities, which ranged from 15.7 to 30.8 per 1000 people.
- People with multiple disabilities are more likely than those with a single disability to experience violence perpetrated against them (35.2 compared with 29.6 per 1000), and 65% of rapes and sexual assaults against persons with disabilities occur against this group.
- Both men (31.8 per 1000) and women (32.8 per 1000) with disabilities have higher rates of violence perpetrated against them than do people without disabilities (14.1 and 11.4, respectively).

These statistics estimate abuse for people with disabilities who are 12 years of age or older living in non-institutionalized households. The statistics are striking, and yet still underestimate abuse. Morgan and Truman (2020) estimate that less than half of violent victimization in general is reported. In a large convenience national survey, only 37% of disabled individuals who experienced abuse reported that abuse (Baladerian, Coleman, & Stream, 2013). The statistics reported above exclude the homeless and residents of institutions, 95% of whom have disabilities (Harrell, 2017). Over 1.49 million people with disabilities and chronic diseases reside in nursing homes (CDC National Nursing Home Survey, 2004). Many of these individuals are elderly and the extent of abuse by guardians and caregivers among the elderly is not well known (Yon et al., 2019; National Center on Elder Abuse, ncea.acl.gov). However, Storey (2020) provides a startling statistic that older adults who experience abuse have a mortality rate three times higher than those who do not experience abuse. Elder abuse, regardless of disability, is a major public health crisis that has not received enough attention. Storey (2020) and Castle, Ferguson-Rome, and Teresi (2015) have summarized the limited research in this area The majority of individuals with disabilities who suffer abuse report that they have never been asked by a health care provider about possible abuse (Oschwald et al., 2009; Powers, et al., 2008; Powers et al., 2002). Examples of possible provider barriers include lack of accessible services and fears about police involvement, mandatory reporting, and a general sense of powerlessness (Oschwald et al., 2009).

Overall, research to date supports the premise that individuals with disabilities commonly know their perpetrators, and that they are at risk to be abused by multiple types of perpetrators (e.g., personal care assistants, spouses). Yon et al. (2019) found that 64.2% of staff admitted abusing an older resident in an institutional setting and that cognitive impairment and disability along with being over 74 years of age and female were primary risk factors of those who were abused. Both men and women who use personal assistance services, whether in institutions or community dwellings, experience a high incidence of neglect, verbal and/or physical abuse, and financial exploitation at the hands of their assistants (Oktay & Tompkins, 2004; Powers et al., 2008; Schulz et al., 2016). In one small retrospective study, parents were reported most frequently as the perpetrator of childhood abuse (defined as denial of activity of daily living care, permission, assistance, or denial of equipment before age 18; Lund et al., 2021). The Department of Justice statistics for noninstitutionalized individuals also provide evidence to support that abusers and those they abuse know each other.

- Forty percent of violence perpetrated against people with disabilities (compared with 32% of those without disabilities) is committed by someone known to them.
- Relatives (parents, children, etc.) account for a higher percentage of violent perpetration against disabled individuals compared with non-disabled individuals (10% versus 6%).
- Intimate partners account for 15% of violence perpetrated against people with disabilities; this does not significantly differ for those without disabilities (13%).

Other reports suggest intimate partner violence against women with disabilities is higher (Copel, 2006; Curry et al., 2011; Mitra, Mouradian, Fox, & Pratt, 2016). Unlike women with disabilities, men with disabilities report sexual violence is more likely to occur by a friend than an intimate partner (Mitra et al., 2016). Being able to recognize the risk factors in both the care assistant and recipient may help psychologists proactively manage abuse risk.

Personal care assistants and intimate partner abusers are likely to experience financial strain, caregiver stress or burnout without adequate coping skills, substance abuse, relationship conflict, and may hold a distorted sense of power and ableist views (Copel, 2006; Curry et al., 2011; Plummer & Findley, 2012; Powers et al., 2008; Storey, 2020). People with disabilities are at risk for abuse or continuing abuse because they are perceived to be powerless, easily exploited, and may be physically dependent or less mobile, socially isolated, overwhelmed by stress without adequate or appropriate coping skills or resources, self-blaming for abuse, emotionally depressed, have difficulty with behavioral regulation, fear retribution or loss of independence, have poor body image, and/or are sexually naïve. Research suggests individuals with intellectual disabilities are more vulnerable to abuse based on limited sexual knowledge and beliefs that others control their sexual experiences (Fisher et al., 2016). They are also at increased risk for becoming a perpetrator because of confused social cues (Bowen & Swift, 2019; Curtiss & Kammes, 2019). Additionally, disabled individuals may lack other options for personal assistance, emergency back-up services, or transportation (Powers et al., 2008; Saxton et al., 2006). Perpetrators, who often engage in repeated abuse, also have less risk of being reported or discovered, and people with disabilities are less likely to be believed or feel nothing will be done if they report abuse or neglect (Copel, 2006; Curry et al., 2011; Curtiss & Kammes; Fisher et al., 2016; Nosek et al., 2001; Plummer & Findley, 2012; Saxton et al., 2006). One reason men with disabilities give for not reporting is that people believe the misassumption that men cannot be abused (Powers et al., 2008; Saxton, et al., 2006). Men are also more likely than women to assume nothing can be done or to blame themselves (Saxton et al., 2006). Research suggests that approximately 21% of people with disabilities who are abused believe the police will not help (Harrell, 2017). Risk of disclosure can also create fear of increased violence, retribution, loss of child custody, or loss of independence (Baladerian et al., 2013; Copel, 2006; Curry et al., 2011; Lund, 2020; Oschwald et al., 2009; Powers et al., 2008). In at least one study, women indicated that they would not report abuse unless they were sure that abuse is what happened (Curry et al., 2011). In other studies, women and men also report being unclear about what constitutes abuse (Lightfoot & Williams, 2009; Saxton et al., 2006). Both studies suggest a need for psychologists to provide education in recognizing abuse and addressing marginalization/oppression that might contribute to this potential ambiguity.

Abuse may affect physical, psychological, economic, and social health. Examples include poorly maintained personal health and physical injury, low self-esteem and self-shaming, depression, anxiety, suicidal ideation, cognitive decline, separation from others, lack of trust and sense of safety, and difficulty keeping employment with resulting financial strain (Curry et al. 2011; Hughes et al., 2010; Kendall-Tackett et al., 2005; Mitchell & Buchele-Ash, 2000; Olkin et al., 2006; Plummer & Findley, 2012; Storey, 2020). Children may also show changes in behavior, such as bed wetting, irritability, and sleep disruption (Martinello, 2014). Sexual abuse also carries an increased risk of pregnancy, gynecological issues, and sexually transmitted disease.

Given that most people do not disclose abuse and the majority of individuals with disabilities report that a health care provider never asked about the abuse, inquiring about abuse is important to consider as a standard component of psychological assessment. Some researchers indicate that use of a screening tool that includes disability-specific questions, such as the AAS-D (Abuse Assessment Screen-Disability; McFarlane et al., 2001), increases disclosure compared with abuse screening tools without disability-specific questions or professional judgment alone (Oschwald et al., 2009; Plummer & Findley, 2012; Storey, 2020). Given disclosure might not be forthcoming, a psychologist's use of a screening tool complemented with the assessment of risk factors and recognition of the effects of abuse can help facilitate identification of abuse, understanding that trust and safety are paramount to the development of the therapeutic relationship.

Mikton, Maguire, and Shakespeare (2014) and Lund (2011) caution that research validating the effects of interventions is limited. However, based on risk factors and effects of abuse identified in the literature, several recommendations listed below apply to psychological practice with individuals with disabilities (Alriksson-Schmidt, Armour, & Thibadeau, 2010; Baladerian et al., 2013; Bowen & Swift, 2019; Copel, 2006; Hickson et al., 2015; Hughes et al., 2010; Martinello, 2014; Mitra et al., 2016; Plummer and Findley, 2012; Powers, Curry, & Oschwald, 2002; Nosek, Hughes, & Taylor, 2004).

1. Know the signs, symptoms, and dynamics of disability-related violence, including the unique areas of vulnerability noted above.
2. Screen for abuse and neglect, and intervene appropriately (see Oschwald et al., 2009 and Robinson-Whelen et al., 2010, for use of a computer-assisted tool for disclosure).
3. Document the history of abuse and neglect.
4. Discuss safety planning with clients, such as having a safe retreat, back-up personal care assistance, and social supports; also include assessment of disaster/emergency preparedness.
5. Maintain current contact information for accessible local domestic violence/sexual assault programs and disability service providers (e.g., Centers for Independent Living).
6. Learn state mandatory reporting requirements for violence against people with disabilities including children, older adults, and dependent adults, and when appropriate involve the person experiencing the abuse throughout the reporting process.
7. Be aware of potential long-term consequences of reporting, including possible deterioration in quality of care and need for accessible domestic violence shelters.

In addition to the actions listed above, psychologists, through individual, couples, and group therapy, may play a key role in reducing potential risk factors by identifying and addressing the needs of the individual and their partners or service providers. Several activities are recommended below, consolidated from the literature cited throughout this section. It is important to keep in mind that these activities will be shaped based on the cultural framework of the client, given their experiences are uniquely affected by their sociocultural circumstances (for example, refer to Lightfoot and Williams, 2009).

1. Provide education on the definitions/types of abuse, using multiple examples, and delineate the boundaries of care (for example, appropriate and inappropriate touch when addressing hygiene).
2. Discuss consensual relationships and healthy sexual development, especially as these are impacted by disability care needs and type of setting.
3. Facilitate education of the partner or caregiver on potential effects of disability on activities of daily living.
4. Help the client identify the abuser's use of power/control in restricting fulfillment of disability-specific needs, if applicable, as well as other aspects of the relationship.
5. Help empower the client through skills development in interpersonal communication and conflict resolution, relationship building, including supervision of the care assistant, active rather than avoidant problem solving, decision-making, stress management, and self-care.
6. Disrupt beliefs that the disabled person deserves to be abused by facilitating development of self-worth and affirmation of value as a person.
7. Discuss potential means to expand social networks to reduce risk of social isolation and create potential safety nets.
8. Teach self-advocacy skills related to interacting with agencies.
9. Evaluate potential readiness of the client to leave the relationship with the person who is abusive. (The Safety Self-Efficacy Scale piloted by Robinson-Whelen et al., 2010, may be useful in helping the client evaluate readiness and confidence in acquiring safety.)
10. Adapt safety plans if the individual has difficulty accessing community resources due to inaccessibility or other related factors; delineate how to get help when needed.
11. Assess need for assistive devices to enhance level of independence and communication.
12. Review signs of abuse and reporting information with a supportive family member (refer to Baladerian, 2013, for practical tips for parents and family members on responding to abuse).
13. Ensure staff are trained to recognize and report abuse perpetrated against individuals with disabilities.
14. Work with the school/other partners to ensure accessible materials are available related to disability and sexuality and that personnel are knowledgeable about the pervasiveness of abuse against people with disabilities and potential warning signs. In one study, domestic violence shelter personnel reported having educational needs related to disability (Chang et al., 2003), but also having success networking with other agencies to serve individuals with disabilities. Psychologists may contribute to improved services for disabled individuals through community networking.

GUIDELINE 11

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

Assistive technology (AT) is defined as devices that are used to increase, maintain, or improve functional capabilities of individuals with disabilities or services that help individuals with disabilities select such devices (Assistive Technology Act, Public Law 108-364, 2004). AT may help individuals with disabilities learn, compete in the work environment, achieve independence, and/or improve their quality of life (NIDILRR, 2019). People with disabilities have widely varying needs; therefore, AT may serve different purposes, examples of which are outlined below.

1. Aids for daily living include self-care aids, such as a fork with built-up handle, bath lift/seat, and button/shoe aids.
2. Augmentative and Alternative Communication (AAC) includes electronic and nonelectronic devices for expressive and receptive communication, such as communication book/boards, eye-controlled communicators, speech synthesizers, and text-to-voice devices.
3. Computer access aids enable people with disabilities to use a computer, including input and output devices (e.g., cursor control accessories), alternate access aids (e.g., head sticks), modified keyboards, switches, and special software (e.g., computer access interfaces/instruction).
4. Environmental control systems are mainly electronic systems that enable people with mobility limitations to control various appliances, electronics, and security systems, such as a Google Home and smart home switches that can be activated by pressure or breath.
5. Home/workplace modifications are structural adaptations or fabrications in the home, worksite, or other areas, such as ramps, elevators, stair lifts, and bathroom modifications, for increasing accessibility.
6. Prosthetics and orthotics provide a replacement, substitution, or augmentation of missing or injured areas of the body, such as knee prosthetics or ankle braces.
7. Seating and positioning are accommodations to a wheelchair or other seating system, such as cushion covers and trunk/pelvic supports, to increase stability, maintain posture, and reduce pressure on the skin.
8. Aids for vision impairment and for hearing access, such as magnifiers, Braille, large-prints, and telecommunications devices for the Deaf, are to help facilitate interpersonal communication and/or environmental engagement.
9. Wheelchairs/mobility aids, such as manual and electric wheelchairs, walkers, and mobility scooters, are used to maximize level of transportation independence.
10. Vehicle modifications, such as adaptive

driving aids, hand controls, modified vans, and acoustic cueing systems, are for personal transportation.

11. Service animals are trained to assist individuals with disabilities with specific tasks, such as item retrieval, navigation in space, and health status alerts (e.g., low blood glucose), to maintain or enhance independence.
12. Recreational assistance are methods and tools, such as three-wheel handcycles, homemade bowling ramps, and write paint brush holders, to enable people with disabilities to enjoy recreational activities.
13. Virtual reality programs and artificial intelligence (e.g., robots), while technically different from AT because of programming, are being used with the same intent as AT, which is to improve function and independence, such as virtual reality programs to facilitate improved mobility and robots to help individuals with autism spectrum conditions improve social skills (Howard, Chen, & Park, 2018; Pennisi et al., 2016).

Although psychologists or other health professionals, such as occupational and physical therapists, introduce, evaluate, and facilitate selection of AT, a client's involvement is key to successful, sustained use. Understanding a client's expectations and to what extent specific devices or aids fit the client's lifestyle, preferences, and values are important considerations in selecting specific AT (Brodwin, Star, & Cardoso, 2004; Falvo & Holland, 2019). A psychologist may work with the client to determine whether selected AT is effective, reliable, relatively easy, and comfortable to use (Brodwin et al., 2004).

It is important to remember that all technologies have advantages and disadvantages. Although technology offers people with disabilities opportunities, AT also imposes client responsibilities. Examples include researching new technologies and assistive devices, learning to use new technology (Pell, Gillies, & Carss, 1999), and funding and maintaining equipment (National Task Force on Technology and Disability Report, 2004). Matching the person with the appropriate technology requires assessing need, milieu, personality, and technology (e.g., Scherer, 2002, 2004). Not all people with disabilities and their families value, are interested in, or are enthusiastic about AT. People may be frustrated when there are high initial or ongoing costs, a lack of customization for the individual's unique needs, incompatibility for use in certain environments or additional barriers due to a device's shape, size, or weight (Howard et al., 2020). While AT may increase a person's independence, it may also pose a social barrier that makes the user feel too different or deficient (Lupton & Seymour, 2000). Even when one person eagerly uses technology to attain objectives or enhance overall sense of well-being, another may find it overwhelming. Appreciating how AT may affect a user's self-image, self-efficacy, coping, and adaptation skills is important for the psychologist when providing AT recommendations (Connor, Kuo, & Leahy, 2018).

Technologies, computer devices, and software programs (e.g., iPads and related apps) are rapidly being developed. For more information about different accessibility apps for people with different type of disabilities, readers can refer to https://iaccessibility.com/. Keeping up with technology's rapid advances to make appropriate recommendations may be difficult. Clients may also find it challenging to learn new technology and stay current with updates. Hence, psychologists strive to maintain awareness of the client's challenges and frustrations with new technology and, to avoid abandonment of the tool, help support their use of AT in daily activities. Psychologists may check their state AT center or refer their clients to appropriate local AT service providers to explore manageable options.

Various professional disciplines are represented in the memberships and activities of the AT field, including the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) and the Association for the Advancement of Assistive Technology in Europe (AAATE). Many APA divisions are also involved and engaged in the development and application of AT for people with disabilities.

Finally, universal design applies to AT, particularly in how AT is designed and accessed. The Disability Act 2005 defines universal design, or UD, as "a) the design and composition of an environment so that it may be accessed, understood, and used to the greatest possible extent, in the most independent and natural manner possible, in the widest possible range of situations, and without the need for adaptation, modification, assistive devices or specialized solutions, by any persons of any age or size or having any particular physical, sensory, mental health or intellectual ability or disability; and b) means, in relation to electronic systems, any electronics-based process of creating products, services or systems so that they may be used by any person" (Authority & Design, 2015). The seven principles of universal design are equitable use; flexibility in use; simple and intuitive use; perceptible information; tolerance for error; low physical effort; and size and space for approach and use (Null, 2013). The purpose of the seven principles is to guide the design of environments, products, and communications. According to the Center for Universal Design at North Carolina State University (1997), the principles "may be applied to evaluate existing designs, guide the design process and educate both designers and consumers about the characteristics of more usable products and environments."

TESTING AND ASSESSMENT

GUIDELINE 12

Psychologists strive to consider the interactions among disability and other individual and contextual dimensions in determining the breadth of assessment.

Psychological assessment has broad implications, including assisting with diagnosis and prognosis; school and vocational planning, re-entry, and monitoring; evaluating the effects of interventions and related services; and resolving disability claims and legal matters, including competency determinations. Therefore, ensuring that tests and broader assessments are reliable and valid for their intended use are significant psychologist responsibilities. Conducting assessments with people with disabilities presents unique considerations to ensure reliable, valid outcomes. In addition to ensuring the psychologist's competence, considerations include, but are not limited to, (1) the effects of the disability and related factors on test selection and provision of appropriate accommodations; (2) the test environment and corresponding administration; and (3) the interpretation of the client's performance based on integration of data.

Several professional associations have developed documents to provide guidance around testing and assessment practices, such as *The Professional Standards of the National Association of School Psychologists (2020)*, *Code of Fair Testing Practices in Education* (apa.org/science/fairtestcode.html), *Rights and Responsibilities of Test Takers: Guidelines and Expectations (APA Joint Committee on Testing Practices, 2020)*, and the *Ethical Principles of Psychologists and Code of Conduct* (2017). For psychologists, the *Standards for Educational and Psychological Testing* (*Standards*) (American Educational Research Association, 2014) is the document that is the most specific in describing appropriate uses of testing and assessment. The *Standards* make the distinction that, in applied settings, psychologists strive not just to *test* individuals, but to *assess* individuals. The *Standards* refer to tests as evaluative devices and to assessment as a broader term, involving the integration of test data with other information, such as educational, social, vocational, and health history. Psychological assessment involves answering questions from which to offer diagnostic impressions, make recommendations, and/or implement appropriate services. As part of the assessment with people with disabilities, traditional testing commonly measures cognition (e.g., intelligence, attention, memory, executive function), visual-perceptual and motoric skills, behavior, emotional status, and personality. (Beyond traditional batteries, one searchable database for rehabilitation measures is sralab.org/rehabilitation-measures). In addition to test results, assessments integrate information from a variety of sources, including personal data (e.g., educational, vocational, health, social, and psychological background), results from inventories, client and collateral interviews (e.g., family, school, health care providers, employers), and/or behavioral observation (*Standards*, 2014).

Conducting assessments, rather than relying solely on testing, provides more comprehensive data to fully support individuals with disabilities, in part because these recognize the importance of context and disability-related fluctuations to performance and outcomes. When conducting psychological assessments, psychologists strive to consider the interaction between the individual with a disability and the environment. Andrews (2020, p.128) indicates that the dimensions of this interaction include "how the individual functions over time, in varied situations, and in response to changing environmental demands" (refer also to Colella & Bruyère, 2011; Radnitz, Bockian, & Moran, 2000; Reed et al., 2005; Simeonsson & Rosenthal, 2001). The person-environment context has also been highlighted in capacity evaluation discussions (Moye, Armesto, & Karel, 2005).

Considering the central role of different contexts in assessing a person's psychological functioning is consistent with the ICF integrative model of disability (WHO, 2001, 2020). Understanding co-workers' attitudes, family members' responses, classroom design elements, or the effects of school or work accommodations may be important dynamics in assessing individuals with disabilities, depending upon the questions of interest (Andrews, 2020; Bruyère & Peterson, 2005; Bruyère et al., 2005; Chan et al., 2009; Peterson, 2005; Reed et al., 2005).

The experience of someone with a disability in specific contexts is also affected by numerous personal factors that lend themselves to assessment. Beyond traditional neuropsychological constructs, examples include overall functional status; coping, adaptation, and social support; and positive psychology concepts, such as meaning, positive growth, positive emotions, and optimism and resilience (Dunn, 2019; Ehde, 2010). Assessing personality factors may also help the psychologist understand the meaning of disability in the client's life, coping in response to stress, and experiencing intervention. When using established methods and instruments as part of assessment, whether it be in neuropsychology and rehabilitation, geropsychology, clinical, counseling, forensic, educational psychology or other specialties, the psychologist is encouraged to reference both client strengths and needs as well as interpret test performance in relation to function. In all specialty areas, it is recommended that the psychologist assess various qualities in a *person* with a disability in context, rather than the *disability* alone.

GUIDELINE 13

Psychologists strive to ensure the validity of assessments by considering disability-related factors when selecting assessment tools and evaluating test norms.

People present with a range of disabilities that may affect the psychologist's selection of tests included as part of a psychological assessment. As for any population being assessed, the psychologist strives to determine whether the assessment tools have been normed with appropriate samples. Who was included in the standardization groups? The relevant validation data should support each measure's use with people who have specific disabilities, just as they support its use for broader populations. Because disability status may significantly alter the meaning of test scores, test developers should strive to either include individuals with relevant disabilities in their norming groups or develop separate norms. For example, some depression scales have been normed without including individuals with specific disabilities. Given these scales measure perceived health, pain, and fatigue, the results might be misinterpreted to indicate a diagnosis of depression when none exists. Conversely, the psychologist might underestimate the effects of depression because items are erroneously attributed only to presenting health issues represented by the same items as depressive symptoms. Hughes et al. (2005) found that women with disabilities had significantly higher levels of depression as well as secondary health conditions (measured independently). They also found that rates of depression varied significantly across people with different disabilities, illustrating the importance of developing norms by disability subgroup.

Unfortunately, studies to develop and establish test norms have commonly excluded disabled people (e.g., Deaf or Blind people) because the methods used are not accessible (Bruce, Luckner, & Ferrell, 2017). Even when test norming includes some people with disabilities, generalizing from one type of disability group to another is not appropriate (Horin et al., 2012). The psychologist needs to determine whether either the test's general norms or any existing specialized norms are appropriate to use with individuals with disabilities based on the similarity of participants and constructs of interest. When standardized assessment instruments lack appropriate norms, the psychologist should attempt to find instruments that maximize collection of valid information and to consult test manuals and publishers for potentially applicable information (*Standards*, 2014). Psychologists should also strive to recognize threats to the validity of their assessment when the individual being assessed is not well represented in relevant normative samples. This becomes even more complicated when an individual with a disability is also part of another under-represented group. (For example, the reader is referred to the Council of National Psychological Associations for the Advancement of Ethnic Minority Interests for a review of testing fairness issues with people of color; https://apa.org/about/governance/bdcmte/ethnic-minority-interests.)

Psychologists are advised to avoid tests with documented biases or significant problems for use with individuals with disabilities. While it is best practice to use tests that are standardized with the disability reference groups of interest, few of these tests exist or match the access needs of individuals with different disabilities. Accordingly, the test battery selected may need to be changed. For example, administering an entire standardized test battery may not be appropriate for someone with a high-level spinal cord injury because of the motoric (e.g., fine motor coordination) and timed components involved. In this situation, it is recommended that psychologists explore the availability of motor-free assessment batteries for the constructs of interest. Similarly, Hill-Briggs et al. (2007) recommend that psychologists avoid cognitive tests that require extensive spoken language skills in the assessment of Deaf individuals whose language construction is not dependent on the structure of spoken English.

Psychologists are advised to remember that the results of assessment and diagnosis may potentially affect an individuals' future legal status. In *Atkins v. Virginia*, 536 U.S. 304, the U.S. Supreme Court ruled that executing people with intellectual disabilities violates the Eighth Amendment's ban on cruel and unusual punishment, but states define who has an intellectual disability. APA has discussed mitigating circumstances for culpability in crimes involving persons with intellectual disabilities. The diagnosis of an intellectual disability has significant implications in this type of legal case, and psychologists need to keep these implications in mind as they strive for valid assessment upon which to base diagnoses.

The psychologist will decide which tests available measure the areas of interest but also simultaneously provide a reasonable opportunity to obtain a reliable, valid outcome when considering disability status. Lombardi et al. (2018) provide a review of construct evidence for common instruments (e.g., depression, personality, ADHD scales) used in higher education with people with disabilities. Psychologists should strive to review previous records and history in making disability determinations and to use the most recent editions of assessment measures as well as determine the appropriate use of particular measures. In reviewing previous records, psychologists should strive to consider the validity of the results obtained through various methods, such as examination of the original protocol if available, which may be particularly important in the context of a forensic evaluation. Psychologists less familiar with psychological assessment with individuals with specific types of disabilities are encouraged to consult with colleagues who possess relevant expertise. Given the lack of available norms, appropriate test selection takes considerable acumen and knowledge of different disabilities and test construction to make informed choices and minimize construct-irrelevant variance (see Standards 9.1-9.3 and 9.7 in the *Standards*, 2014). Bersoff, DeMatteo, and Foster (2012) as well as the *Standards* aptly describe the importance of test user qualifications.

GUIDELINE 14

Psychologists strive to provide appropriate accommodations to individuals with disabilities to optimize meaningful participation in the assessment process.

Disability-related issues affecting test access (e.g., physical, cognitive, linguistic, etc.), and thus outcome, may necessitate taking advantage of the allowance for exceptions, such as different presentation modes or abbreviated testing, noted in the *Standards* (2014). Failure to provide appropriate test access may result in inaccurate diagnoses or therapeutic interventions that do not match the client's needs. Care must be taken to not diagnose a medical condition for what may be a cultural or disability-related difference that can be mitigated by providing appropriate accommodations. It is also important to remember that individuals with disabilities may or may not require accommodations for assessment.

To assess what accommodations the client may need to complete assessment batteries, having an open dialogue with the client and/or their parent/guardian about the client's needs can be very helpful. A psychologist might ask their client, "When you completed exams in school, did you ever receive any accommodations?" or "Have you ever received accommodations for a work assessment?" For example, a Blind or low-vision client might say they typically have test questions read aloud to them, provided in Braille, or audio recorded. Similarly, a job applicant with a learning disability might request time and a half to complete a written vocational test. However, not all clients will be aware of their eligibility and/or need for specific accommodations. Determining whether an accommodation is appropriate depends on both: (1) the presentation of the disability and associated factors and (2) the variables being assessed. Importantly, psychologists use their clinical judgment based on all available information to determine if an accommodation should be discussed with their client. Testing accommodations are discussed in detail below.

A testing accommodation is, in essence, a change in test format or presentation, test administration, or response procedures that does not alter the construct being measured, making scores comparable with the original test (*Standards*, 2014). Consider the following example: an individual wearing glasses can clearly see the items on the visually based test they are taking. Being assessed without their glasses might result in poor performance simply because the individual could not see the test used. Thus, a score falling in the impaired range would have nothing to do with the individual's competence on the tasks presented. Making accommodations helps the psychologist assess clients with varying levels of ability by removing access barriers that would likely affect the individual's results. An accommodated measure is expected to yield more valid results than the same measure without such accommodations. Still, validation research is always appropriate. Psychologists working with children may find Abedi and Ewers (2013) work quite helpful in considering accommodations. The researchers reviewed the evidence for use of a variety of accommodations for school-aged children based on whether each accommodation meets five conditions: effectively increases test accessibility, is valid, is sensitive to the student's background, is appropriate, and is feasible.

Accommodations are distinguished from modifications. Accommodations are testing changes that are not believed to fundamentally alter the construct being measured, whereas modifications are testing changes that may change the intended construct (Andrews, 2020). Similar to accommodations, the purpose of a modification is to improve accessibility while keeping intact as much of the original construct as possible (*Standards*, p, 190). The *Standards* present the example of a student with dyslexia (specific learning disorder in DSM-5) using a screen reader for a reading comprehension test involving decoding. When decoding is part of the construct, the screen reader (which reads passages aloud for the student) would be a modification because the student's scores would only reflect comprehension and not decoding. Therefore, the scores would not be comparable with those tested without a reader. On the other hand, a student with a visual disability using a large-print format for a reading test whose construct is comprehension may also need additional time to accommodate turning pages. Without the accommodation of extra time, which is unrelated to the construct being measured, assessing the student's reading ability would be incomplete, resulting in a lower, less valid score. Fortunately, for many educational tests, the general norms work adequately for people with disabilities receiving accommodations.

The 2014 *Standards* identified a variety of ways that tests might be adapted for administration to individuals with disabilities. Examples include (1) altering instructions or presentation format; (2) altering response format; (3) altering timing; (4) altering setting; (5) eliminating test items or section; 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 alternatively administered in Braille, audiotape formats, or computerized. Permitting test takers with disabilities to use alternative response formats allows them to record their answers more accurately. Some test takers may also require assistance from an aide. An individual with an extreme movement challenge may have difficulty filling in bubbles on an answer sheet such that they are provided the accommodation to state the responses that are then filled in by someone else. When no other options are available, psychologists might develop an appropriate accommodation, but it would have to be clearly documented.

Altering testing time is often a valid accommodation, especially for academic achievement tests and when time is not a central construct. Changing the testing time frame for those with low stamina or attentional focus may be very helpful. Altering the setting is also a common accommodation, typically to make it physically accessible and/or to reduce distracting stimuli and noise. Partial use of a test typically occurs when the disability affects one's valid responding to specific components, such as motoric components of a standardized test battery. This would be the case for someone without functional use of hands (e.g., for some individuals with bilateral amputation, Parkinson's, or quadriplegia). Finally, using a replacement or alternative measure may be possible if it has comparable validity and is less influenced by the disability. Alternative assessment tools are sometimes used to assess academic achievement of individuals with intellectual disabilities who have alternate achievement standards (i.e., academic proficiency expectations) in the same subjects that other students take (Quenemoen & Thurlow, 2015; U.S. Department of Education, 2018; ncscpartners.org).

Psychologists strive to know about these processes when collecting school-related information and participating in assessment, IEP development, and other intervention planning.

If a disabled individual requires accommodations, psychologists are mandated to provide them under Section 504 of the Rehabilitation Act. They are not optional. Unfortunately, Horin et al. (2012) found in her study that only one-third of vocational rehabilitation professionals, mostly psychologists, indicated making any test adaptations in the past year. When adaptations were made, the most frequently occurring changes were giving an alternate test format and translating or interpreting tests. The psychologist's responsibility is to try to remove bias from assessments based on providing appropriate accommodations or modifications. To enhance decision-making, psychologists benefit from knowing whether a test publisher approves of certain accommodations for individuals with specific disabilities. Ideally, the accommodations should have been evaluated with such individuals by the test publisher and found to represent the construct underlying the test for members of the specific population (Standard 3.1, *Standards*, 2014). Significantly more research is needed to evaluate test administration accommodations and modifications.

When either modifications or adaptations are needed that affect the constructs being measured, the psychologist should document the exceptions and corresponding limits to interpretation in the report of findings so that other psychologists may clearly understand the effects of construct alterations. This practice is consistent with the *Standards* and the APA Ethics Code (Standard 9.06 Interpreting Assessment Results) and may also be of benefit if a different psychologist completes follow-up assessments. On the other hand, flagging scores simply because accommodations are made is not appropriate. *Flagging* is a controversial practice wherein an asterisk identifies scores earned by individuals taking an accommodated test. Typically, but not exclusively, flagging has been used in making academic admissions decisions. The ADA prohibits "flagging policies that impede individuals with disabilities from fairly competing for and pursuing educational and employment opportunities" (https://ada.gov/regs2014/testing_accommodations.html). Accommodations are provided to establish a fair assessment situation; therefore, accommodations that do not alter a construct should have no bearing on test interpretation. The reader is referred to Sireci (2005) for a discussion of flagging and the reasons testing agencies recommended discontinuing its practice.

GUIDELINE 15

Psychologists strive to validly assess individuals with disabilities by appropriately adapting test administration based on disability-related factors.

The experience of disability is typically not static. Suboptimal performance may occur if the test giver is not attuned to fluid factors affecting the experience of disability. Disability-specific factors that are irrelevant to the construct being assessed but affect the outcome result in a lack of fairness in the testing situation and affect the validity of the psychologist's interpretation of the individual's abilities and/or skills (*Standards*, 2014). It is the psychologist's ethical responsibility to take appropriate steps to ensure the intended constructs and not disability-related factors are being measured.

Common factors related to disability that can affect both the reliability and validity of assessment include physical strength, balance, and coordination; spasticity; energy level and stamina; timing of medication effects; processing and attentional speed; behavioral dysregulation; rate and clarity of communication; pain experienced; and needs related to bowel and bladder function. It is recommended that providers try to identify these issues based on records review and clinical interview before initiating assessment to anticipate potential adjustments needed during the test administration process, especially given these factors may vary based on environmental demands. For example, the examiner may need to spread testing across multiple sessions based on considerations of fatigue or cognitive overload. The psychologist needs to also be aware of potential comorbidities that may affect assessment, such as seizures, and individual characteristics, such as preferences for familiar people and predictable routines commonly seen in individuals with intellectual disabilities and autism spectrum conditions (Szarko, Brown, & Watkins, 2013; Thompson et al., 2018). Szarko et al. (2013) showed that rapport building could facilitate test taking with people with autism spectrum conditions. This work suggests that planned strategies before assessment to address disability-related issues may affect overall validity. Thompson et al. (2018) provide suggested accommodations by domain (e.g., behavioral, sensory, etc.) for individuals with intellectual disabilities. Being familiar with disability-related factors and possible accommodations will also help the psychologist proactively implement strategies that establish an appropriate testing environment, whether in person or virtual. The assessment environment and its accessibility include physical access as well as other aspects of access, such as communication as discussed in Guideline 5.

GUIDELINE 16

Psychologists strive to validly interpret assessment results based on consideration of co-occurring factors impacting the performance of individuals with disabilities.

Although many psychological tests have not included people with disabilities making both test selection and interpretation challenging, resources exist to help psychologists in their conceptualization of assessment results. Hill-Briggs et al. (2007) provide a comprehensive review of tests and accommodations commonly used with persons with different types of disabilities, with a particular focus on those with hearing and visual disabilities. They also include a discussion of factors to consider in test interpretation, including when there are no specific norms for people with disabilities. Age of disability onset may affect developmental progression of skill development, type of communication may affect processing of test instructions and materials, and comorbidities may suppress performance that is erroneously attributed to disability. Anxiety and depression are common correlates of chronic pain; traumatic brain injury, sometimes undiagnosed, commonly co-occurs with spinal cord injury; and autism spectrum conditions and anxiety commonly occur with intellectual disability (Thompson et al., 2018). Psychologists should also strive to be aware of non-disability factors that may affect test performance and, thus, interpretation of scores. The reader is referred to the APA *Handbook of Multicultural Psychology* (Volumes 1 and 2) for relevant discussion. For example, Suzuki, Naqvi, and Hill (2014) present the concept of stereotype threat in which the test taker's underperformance is a consequence of anxiety related to being judged by the negative stereotype of one's group (in this case having a disability). This commentary is consistent with the discussion of Bersoff et al. (2012) about collaborative assessment, a positive consequence of which is reducing any misunderstanding between assessor and test taker. These types of compounding issues may result in suboptimal performance even with appropriate accommodations. In addition, both Hill-Briggs et al. (2007) and the *Standards* (2014) include a caution that disability is not a unitary construct (also noted in *Guideline* 14). Understanding the person's individual disability background and stability are crucial to interpreting performance. Children with cerebral palsy who have co-occurring intellectual disabilities perform less well over time on activities of daily living than those without intellectual disabilities (Warschausky, Van Tubbergen, & Hasson, 2019). As further illustrations of this point, Hill-Briggs et al. (2007) note that individuals may acquire vision loss at different ages and have different levels and types of vision loss, interacting not only with neuropsychological test performance but also higher cortical function. Similarly, the mode of communication used by Deaf individuals (signing vs. cued speech) during development impacts cognitive processing and therefore influences neuropsychological test performance focusing on this ability. As previously noted, specific test items may confound interpretation when they describe physical factors or similar characteristics that are meant to reflect potential pathology, when in fact they simply reflect aspects of disability (Johnson-Greene & Touradji, 2010) (e.g., slowed initiation of activity due to multiple sclerosis; fatigue secondary to sleep disrupted by traumatic brain injury). Test selection and administration directly influence test interpretation (Bush & Rush, 2019).

Although one cannot account for every idiosyncratic characteristic, universal design concepts, when applied to test development, will significantly improve the validity of test interpretation. While accommodations focus on removing barriers (e.g., physical, sensory, cognitive, emotional), the intent of universal design is to make assessments fair for all test takers, regardless of disability characteristics (or other sociocultural factors). Universal design seeks to build flexibility into item–response format during test development (Ketterlin-Geller, 2005). As Ketterlin-Geller states, "the cornerstone of applying the principles of universal design to assessment is the elimination of inherent test characteristics that differentially influence student performance in the tested domain" (p. 18). Another might be to find ways to reduce the anxiety of the situation for those who find test-taking a particularly stressful activity. Providing advance information about the nature of the testing activity and what to expect or inviting an opportunity to explore the testing environment in advance of the actual session may be useful to reduce anxiety about the actual testing event.

Universal design allows a clearer distinction between actual performance on the construct being measured and superfluous factors that interfere with that performance, resulting in conclusions that either over- or under-estimate skills and abilities. Universal design will not eliminate the need for accommodations, but it will go a long way toward ensuring fairness. Meanwhile, psychologists working with people with disabilities are encouraged to be extremely vigilant in all aspects of assessment to support accurate interpretation. As noted in the *APA Guidelines for Psychological Assessment and Evaluation* (2020), "conclusions and/or recommendations resulting from use of instruments are expected to be fair; minimize bias; and are consistent with applicable standards or practice, policies, and laws" (p. 15).

Depending upon the specific questions the psychologist is trying to address, the psychologist may find multi-modal assessment useful to identify consensual patterns of performance and to address functional relevance. Multimodal assessment may help offset lack of normative data and lack of validation studies in interpreting results. It may also prevent bias that can result in needlessly grave consequences, such as children being taken away from their parents without cause (noted in *Guideline* 9). Multimodal assessment is discussed in *Guideline* 17.

GUIDELINE 17

Psychologists strive to conduct appropriate multi-modal assessment to provide diverse information to support valid interpretation of assessment results.

Psychologists are encouraged to utilize multiple modes of assessment tools to gain a holistic understanding of their client's needs. Multi-modal assessment recognizes multiple contributors to the definition and experience of disability. Test data combined with qualitative and functional assessments may provide rich additions to assessments for people with disabilities. As noted in *Guideline* 13, assessment can include consideration of the individual interacting with the environment, and a multi-modal approach provides a broader representation of how the person works in and adapts to various environments. Multi-modal assessment also helps bolster interpretations that would otherwise rely solely on tests without sufficient norming for people with specific disabilities. Based on the integration of different types of data and information, the psychologist may reinforce the accuracy of interpretation by identifying converging and diverging patterns. When discrepancies are encountered across different data types, the psychologist needs to consider the variables discussed in *Assessment Guidelines* 12–16 in attempting to reconcile differences as well as report any limitations to the interpretation or inferences made about the disabled individual.

The components and extent of a multimodal assessment will depend on the constructs of interest. Standardized batteries and other tests may provide useful quantitative information for specific disability subgroups. However, quantitative measures tapping various domains, including different test scores, provide only one part of the overall performance picture. Specific strengths (e.g., psychological, spiritual, social, physical, and/or cognitive strengths) along with specific environmental adaptations for individuals with disabilities may counter-balance specific challenges resulting in more inclusive and independent participation in different domains of daily life. As noted in the *Standards* (2014), "the test user should not ignore how well the test taker is functioning in daily life" (*Standard* 9.13, p. 145). This is particularly the place where qualitative and functional data complement quantitative test data. An individual who performs poorly on tests assessing cognitive function may, nevertheless, do fine in a familiar, structured home, school, or work setting with or without accommodations. Conversely, through the use of multi-modal assessment, the psychologist may make important observations (e.g., regarding environmental stimuli; differences in performance at school, work, or home; parenting style; social interactions) that directly point to useful areas of intervention or that prevent misassumptions based on the spread effect where, for example, behavioral issues unrelated to disability are attributed to the disability without observational or social information to corroborate this attribution.

Since these *Guidelines* were originally published in 2011, research and reviews of research using qualitative data have proliferated. Such research includes research focused on psychotherapy with disabled clients (Olkin, 2017); children with disabilities and/or their parents (Alsem et al., 2017; Shields & Synnot, 2016); other caregivers (Lloyd, Patterson, & Muers, 2016); specific disability groups (Fadyl et al., 2019; Mahdi et al., 2017; Rose et al., 2019; Shirazipour et al., 2018; Silverman et al., 2017; Van den Bogaard et al., 2019); and disabilities in general (Hayre & Muller, 2019; Quale & Schanke, 2010). Lloyd, Patterson, and Muers (2016) have described qualitative research as a means to explore the subjective experience of disabled individuals, something for which quantitative methods are not designed. These data are useful in learning more directly about experiential aspects of disability to design appropriate interventions and policies. Therefore, a primary way for psychologists to gain an understanding about the experience of relevant disability subgroups is to read this type of research.

At the individual level, qualitative assessment is commonly used as part of a mixed-methods approach to assessment (e.g., clinical interview, behavioral observation, etc.). Qualitative assessment typically involves at least a semi-structured interview or focus group with disabled individuals and/or other people who are part of their daily life (e.g., school, work, home), the purpose of which is to understand the person's lived experience to gain a more holistic picture of assets and challenges. Qualitative measures may be especially useful with children with disabilities, individuals with multiple barriers to other forms of assessment, and when no psychometrically appropriate measures are available. Bruce et al. (2017) stated that standardized assessment is inappropriate for Deaf-Blind children and that effective assessment requires input from multiple adults across natural environments familiar to the child. The researchers provide a review of practice evidence in assessment for Deaf, Blind, and Deaf-Blind children.

In assessing a client with a disability, a psychologist may conduct an integrated, semi-structured interview focusing on the client's relevant disability-related issues, their relative importance among various personal concerns, and how the experience of disability interacts with other psychological issues (Mohr & Beutler, 2003). When appropriate in the context of the assessment goals, the psychologist may ask about the following: the client's type and origin of disability; perceived disability-related strengths and needs; the functional impact of the disability; others' reactions to the client's disability; required accommodations, aids, treatments, and medications; and necessary lifestyle modifications (Olkin, 2012). When the client uses AT or requires accommodations, the psychologist is advised to incorporate them into any behavioral observations or interviews to avoid capturing an unaccommodated disability rather than the target behavior (Einarsson et al., 2020; Olkin, 2012).

Functional assessment measures how a person interacts with the environment and focuses on various domains of real-life skills (e.g., strengths, adaptive coping skills) that enable the person to engage independently in various settings (Heineman & Mallinson, 2010; National Association of School Psychologists, 2010; Shriver, Anderson, & Proctor, 2001). Functional assessment may include both use of functional measures and observation. Like qualitative assessment and specific adaptive behavior assessment, functional assessment measures may be particularly useful for clients with intellectual disabilities and those with multiple barriers to testing (Tasse, 2006; Tasse et al., 2012). Functional assessment measures may include items that involve observation of a range of skills in the client's living, working, social, and/or learning environments and portray the extent of the client's adaptive behavior. The assessment may cover social and recreational behavior; activities of daily living, family, school, or work behavior; and/or communication, motor skills, and functional academic skills. Functional assessment also incorporates disability accommodations as part of the process. For example, in order for the psychologist to validly assess parenting skills for an individual with mobility restrictions, 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; Peterson, 2005; Reed et al., 2005). Several functional assessment measures have adequate reliability and validity for people with disabilities, and the advent of computerized administered testing has helped reduce the number of items and amount of time needed to complete functional measures (Heinemann & Mallinson, 2010), although some concerns have been raised about the algorithms for doing so.

Depending upon the range and type of skills assessed, clinical observation may accompany use of functional assessment measures. If observation is used that is not associated with a validated functional rating scale, psychologists are encouraged to consider establishing guidelines and a basic checklist of questions for these assessments somewhat akin to quantitative testing (even though norms are not available). Examples of these types of questions include:

1. What is the purpose of the observational assessment?
2. What concrete constructs is the psychologist trying to learn more about or what questions is the psychologist trying to address?
3. How will the psychologist know when each construct is demonstrated? How is performance rated or evaluated?
4. How long should the functional assessment last?
5. What settings facilitate likelihood of constructs of interest being observed (e.g., home kitchen for safely sequencing cooking steps, work setting for assessing appropriate use of accommodations to enhance work performance, etc.)?
6. Are multiple settings required to be confident in behavioral consistency?
7. Who are the participants and observers or bystanders? Do they hinder or facilitate constructs of interest, and how?
8. What external factors, if any, seem to contribute to or hinder demonstration of the acquisition of constructs of interest (e.g., accommodations used, environmental contingencies or setting, construct-irrelevant occurrences)?
9. What disability-related factors are affecting performance (e.g., arousal, psychomotor function, behavioral mannerisms, speech difficulties, medical symptoms)? Did anything help ameliorate observed difficulties?
10. What additional factors are contributing to changes or variations in performance observed within or across settings and time (e.g., interpersonal skills, mood, frustration tolerance, adaptation to changes, support given)?
11. How will the information gathered be used?

Information may need to be collected not only using different sources, but also across time given contextual and developmental factors that affect performance. The selection of appropriate time points will be directly affected by the purpose of the assessment, such as related to school planning or capacity determinations. Establishing some general consistency in one's approach to information gathering may assist the psychologist in collecting appropriate collateral information and minimizing bias, as well as potentially beginning to create an internal pool of information on relevant groups with whom they work. A consistent approach to information gathering may be particularly useful if the psychologist works with individuals who have less common disabilities or have significant comorbidities (making it unlikely standardized data would be available because norming pools would be too small).

In summary, psychologists are encouraged to consider a multidisciplinary perspective in assessing clients with disabilities, because clients commonly face barriers based on a combination of factors (e.g., social, environmental) that can impact assessment results and subsequent interpretation. Psychologists may also learn from their peers in other professional domains, including special education, clinical, occupational, and community rehabilitation. Functional assessment of work-related communication and social skills of a person with a severe brain injury, for example, may require a team comprising a psychologist, speech-language therapist, occupational therapist, social worker, vocational rehabilitation counselor, and others. Importantly, psychologists who perform assessments with persons with disabilities are encouraged to become familiar with key knowledge of disabilities to facilitate appropriate selection, administration, and interpretation of available assessment information. Understanding the disability and associated factors provides the foundation from which to evaluate whether the disability is relevant to the assessment process. By possessing critical disability knowledge, the psychologist may more effectively consider different types of data and information to include in an assessment, such as those summarized below, that support inferences made and resulting consequential outcomes.

- **Medical information**—comorbidities, medications, types of injuries, physical manifestations of disability, behavioral presentation affected by disability-related factors, developmental changes, psychological history
- **Clinical interview**—disability identity and related beliefs (e.g., cultural, spiritual), perceived strengths, familial roles and other social system supports (or dysfunction) related to inclusivity, behavioral and affective presentation, how disability intersects with life goals
- **Test data**—quantitative measures of constructs, effects of accommodations
- **Functional assessment data and observations**—task performance in relevant daily life environments; observation in real time
- **Records and inventories**—school and vocational information demonstrating patterns of performance over time with and without accommodations
- **Third-party information**—observations and input from other health care providers, school officials, employers, families, attorneys, etc., that might reflect behavioral patterns, adaptations, and relative strengths and weaknesses
- **Demographic and cultural information**—ethnicity, overall educational level attained or completing, employment and income, neighborhood, and social supports (e.g., accessible transportation, recreational facilities and parks, churches and synagogues, stores) that might affect coping resources.

GUIDELINE 18

Psychologists strive for accurate interpretation of assessment data by addressing personal biases and assumptions regarding individuals with disabilities.

Psychologists attempt to recognize any personal conceptions of and reactions to disability that may bias their interpretation of assessment data. By involving clients in a collaborative feedback process with the assessment results (Farley, Bolton, & Parkerson, 1992; Finn & Tonsager, 1997) and by using multiple independent information sources (Holzbauer & Berven, 1999; Vanderploeg, 2000), psychologists may help safeguard against bias-related issues negatively impacting assessment outcome.

Some literature on fairness in psychological assessment suggests several strategies for removing or minimizing bias. These strategies include

1. Delaying professional judgment and decision until *after* rather than *during* an evaluation (Sandoval, Frisby, Geisinger, Scheuneman, & Grenier, 1998; Tasse, 2006);
2. Identifying personal preconceptions about persons with disabilities (Sandoval et al., 1998);
3. 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);
4. Developing complex schema 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
5. Specifically addressing both strengths and weaknesses in functioning and focusing on the referral question (Schultz & Stewart, 2008).

Overall, psychologists strive 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, 2016; Olkin, 2017). Care in this regard needs to be exercised by psychologists performing assessments in high stakes, potentially contentious contexts, such as criminal cases and medicolegal assessments for entitlement to disability benefits that utilize special methods for evaluation of symptom validity and effort.

Even with the use of multi-modal assessment, Carone and Bush (2018) have argued strongly for the inclusion of validity assessment by psychologists conducting assessments with individuals following disease, illness, or injury. (Please note that one exception is that validity assessment is *not* indicated for people with severe neurological impairment who require 24-hour care (Bush & Rush, 2019).) The intent of validity assessment is to determine whether the individual has put forth enough effort to perform well (preventing possible over-representation of need) or, conversely, has exaggerated responses (resulting in possible under-representation of need). Even with the implementation of appropriate accommodations, the psychologist still needs to distinguish between performance reflecting ability and under- or over-performance related to psychological issues, such as malingering or conversion disorder. In addition to medicolegal issues, Carone and Bush (2018) cite numerous reasons that may lead to invalid test performance, such as avoidance of responsibilities, attention seeking, poor insight, attempts to escape dangerous situations, and financial need. Johnson-Greene and Touradji (2010) note that motivation may also be affected by factors such as pain, fatigue, or depression. Without having confidence that the individual's performance is valid, the psychologist cannot rely on the assessment results to base clinical decisions. Carone and Bush (2018) also point out that behavioral observations and clinical judgment are insufficient to make validity decisions. Their commentary suggests that psychologists be vigilant regarding these types of issues as well as self-reflect on any potential professional motivations for presenting the individual in a favorable light (e.g., advocating for someone who has been marginalized, financial incentive for disability claim to succeed). Actions related to personal gain would violate multiple sections of the APA Ethics Code. Carone and Bush suggest a separation of roles, such that the clinician does not serve as the forensic expert, even though they will likely still provide clinically relevant data (often under subpoena) based on working with the disabled individual. Such a boundary helps remove an inherent conflict of interest that could potentially violate the ethical principle of nonmaleficence. This separation is also consistent with *Guideline* 1.02 Impartiality and Fairness, 1.03 Avoiding Conflicts of Interest, and *Guideline* 4.02 Multiple Relationships and its subcomponents from the *Specialty Guidelines for Forensic Psychologists* (APA, 2013). Simply conducting an assessment does not mean the psychologist is competent in forensic evaluation. Psychologists performing evaluations in this context are encouraged to consult the *Specialty Guidelines for Forensic Psychologists* (APA, 2013) and stay abreast of the literature. Similar care needs to be exercised in parenting, vocational capacity, and other evaluations for court purposes, especially in highly consequential situations, such as competency-to-stand-trial determinations in which standardized approaches are advised (Perlin, 2004).

Summative recommendations for psychologists working with people with disabilities include, but are not limited to, the following:

1. Clearly define the purpose of the assessment and the constructs needing to be assessed.
2. Before testing session(s), meet with the client to understand disability-specific characteristics related to constructs of interest; describe assessment (and subsequent results) in understandable terms that avoid jargon.
3. Review test manuals to understand norming samples and applicability to individuals or groups with specific disabilities.
4. Maintain standardized procedures if accessibility based on disability characteristics and related factors is adequate.
5. Identify specific accommodations needed to improve test accessibility.
6. Acknowledge that not all tests may be appropriately adapted.
7. Select tests that align most closely with both client characteristics and constructs of interest.
8. Create an environment ahead of time to maximize test access that supports achievement of a valid test performance (e.g., remove distracting stimuli, plan breaks, manage room temperature).
9. Schedule assessments at times expected to maximize performance (e.g., when medications are typically working at their peak and producing the fewest side effects, when the person is well rested).

10. Anticipate adaptations that may be needed during and across assessment sessions based on potential construct-irrelevant variance that may occur.
11. Review demographic and sociocultural factors intersecting with disability that may affect test scores (e.g., educational level, ethnicity).
12. Identify comorbidities that may affect assessment results (e.g., substance abuse, seizures, pain, emotional status).
13. Consider test items that overlap with physical (or other) characteristics of the disability.
14. Acknowledge one's own personal biases related to disability or related characteristics that may influence interpretation of assessment results.
15. Conduct multi-modal assessment to increase validity of interpretation.

INTERVENTIONS

GUIDELINE 19

Psychologists strive to identify their readiness to address their clients' disability-related concerns.

Psychologists provide interventions with disabled individuals and their families in a variety of settings, including outpatient and inpatient health care facilities, private practices, schools, employment settings, forensic settings, social service agencies, and disaster sites. For example, people with disabilities may be disparately impacted by emergency situations, such as those created by natural disasters (e.g., safety exits, access to health care) (Dodgen et al., 2016; Taylor, 2018). The psychologist's awareness of and appropriate sensitivity to disability-related issues is important to competent practice in any setting in which the psychologist provides services.

Although psychologists need to guard against presuming disability is the central reason a client seeks psychological services (as noted in *Guideline* 2), there are several potential issues linked either directly to disability and/or the effects of marginalization based on disability that are amenable to intervention for which a client and family may request services. It may also be the case that the client or family may not seek services based on their experience of disability, but that disability-related concerns relevant to the presenting issue may be identified or suspected during psychological assessment or arise as intervention progresses as the psychologist learns about the client's life experiences and/or the client becomes more aware of how specific experiences connect to each other.

Psychologists are encouraged to review the non-exhaustive list of possible areas of intervention below to self-reflect on their readiness to address these issues if they arise in their practice with clients with disabilities.

1. Planning and monitoring study skills strategies designed to maximize cognitive and academic performance (ultimately impacting economic self-sufficiency)
2. Participating in IEP development (parental and student preparation, strategy development and implementation, liaising with school personnel)
3. Facilitating positive disability identity development, which may include reframing beliefs and values imposed by non-disabled individuals that have been incorporated into the client's own beliefs and values
4. Managing bullying and discrimination related to disability
5. Managing pain, depression, anxiety, PTSD, suicidal ideation, or behavioral issues, the expressions of which are commonly mediated by multiple factors (psychological, physical, sociocultural, economic, and/or environmental)
6. Supporting development and maintenance of healthy friendships in school environments (and minimizing risk of joining problematic friend groups because of fear of social isolation based on disability)
7. Assisting with strategies to develop/support/maintain personal relationships and social support networks and interest in connecting with disability communities
8. Facilitating development of resilience and self-efficacy
9. Developing and implementing cognitive training programs
10. Facilitating appropriate compensatory strategies and accommodation selection and use for personal, social, and academic/work environments
11. Facilitating development of emergency plans for safe exit from commonly accessed indoor and outdoor physical spaces
12. Addressing reactions and concerns related to use of AT in social contexts
13. Addressing the development/maintenance of healthy body image
14. Supporting the development of sexual identity and expression and strategies for problem-solving potential challenges associated with sexual expression/intimacy (e.g., physical, environmental, and communication needs)
15. Facilitating constructive coping, safety, and self-esteem after sexual abuse/violence
16. Working with families and personal care assistants to address disability-related knowledge, stress management, connection to resources, and how to foster constructive relationships that help the client maximize level of independence
17. Navigating civil rights and disability laws, and financial resources and challenges, and facilitating the development of self-advocacy
18. Facilitating constructive communication strategies to respond to the public when they commit microaggressions or boundary transgressions

19. Evaluating and managing medications as well as risk of or actual substance abuse (e.g., contexts, perceived need and outcomes, rationale for decisions for under- or over-use of medications)
20. Strengthening coping overwhelmed by the effects of multiple marginalized intersections (LGBTQ and disabled; Black and disabled, etc.)
21. Facilitating transitions from one developmental stage to the next (e.g., school, work, partnership, retirement)
22. Promoting healthy behaviors to foster quality of life and prevent complications that risk reduction in independence (e.g., fall prevention, exercise strategies, sleep routines, monitoring body's cues)

If a client does not present with disability-related issues the psychologist believes are relevant to the presenting concerns, inquiring about the impact of disability is ethically appropriate by considering certain parameters. These include being able to justify the content relevance of the inquiry, the timing of the inquiry, and the client's readiness and resilience (with intent to avoid harm and facilitate progress). Generally, information the psychologist gathers may be useful in assessing the benefits and risks of specific recommendations or intervention pathways. Olkin (2017) suggests the following type of question: "Do you think your disability plays a role in this problem [issue]?" This approach empowers the client to choose whether disability is relevant and, if so, whether the client is interested in or has insight to address this aspect of intervention. Asking the question of the client also communicates that the psychologist is willing to explore rather than avoid disability-related issues, which can enhance the therapeutic relationship and collaborative process of intervention. Psychologists, regardless of years of experience, should seek additional knowledge, training, and consultation when working in less familiar or new areas with clients with disabilities. (For example, discussing sexual behavior and well-being may be a topic some psychologists are unfamiliar with or uncomfortable approaching. Mona, Cameron, and Cordes (2017) have recommendations in this important area.)

GUIDELINE 20

Psychologists strive to recognize that their choice of therapeutic approach is not dependent on the type of disability.

Psychologists are advised not to assume that certain treatment modalities, interventions, and theoretical orientations are appropriate or inappropriate based on the individual's type of disability. For example, a misassumption might be made that a client with an intellectual disability receives little benefit from individual psychotherapy (Butz, Bowling, & Bliss, 2000; Mason, 2007) or that the client does not recognize the benefit of therapy. In one study, clients with intellectual disabilities acknowledged problematic behavior, expressed that the therapy in which they were engaging was helpful, valued the supportiveness of the therapeutic relationship, and connected therapy to goals and outcomes, with concerns expressed about maintaining progress (Pert et al., 2013). Psychotherapy, regardless of the client, is shaped by the psychological concerns; the client's strengths and goals, negotiated with the psychologist; and meaningful, reasonably expected therapeutic outcomes based on available practice evidence. (For example, refer to the systematic reviews of cognitive rehabilitation programs by Cicerone et al. (2019) and Goverover et al. (2018), which include practice recommendations.) Potential therapeutic outcomes will depend on the therapeutic relationship and a realistic intervention plan within which to address goals and the psychologist's ability to understand the client's life circumstances (i.e., relevance to daily life), which may be more complex for people with disabilities.

Psychologists may find two resources helpful related to empirical bases for intervention. Livneh and Martz (2012) provide a detailed analysis of the literature on adaptation to disability and empirically supported approaches that demonstrate the complexity of disability-related issues. Similarly, in their chapter on rehabilitation psychology, Turner & Bombardier (2019) review several common areas of intervention for individuals with disabilities and the evidence base for addressing important areas, such as depression, anxiety, and family issues: They report, for example, that problem-solving approaches have the strongest empirical support when working with families of disabled individuals. Andrews (2020) also provides a review of disability-related factors in intervention as well as risk factors for suicidal ideation.

Olkin (2017) describes the use of disability affirmative therapy (D-AT) as a process that cuts across different theoretical orientations and facilitates mutual understanding of the client's current functioning by incorporating "key aspects of disability experiences and the role of these experiences in the client's current functioning, presenting problems, and relationships" (p. 5). Although this approach has not been empirically validated yet, psychologists unfamiliar with D-AT are encouraged to review this approach to gain a broader understanding of areas to explore regarding how the meaning of disability may shape the client's current presentation and the psychologist's potential therapeutic decisions.

Additionally, group counseling and psychotherapy have been used with a wide range of people with disabilities to address concerns and needs with regard to physical, psychological, social, vocational, financial, environmental, attitudinal, and recreational needs. The four modalities used most often are educational, social support, psychotherapeutic, and coping and skill training groups. Goal setting also encompasses affective, cognitive, and behavioral areas. Studies also show that building peer support networks and connecting people with disabilities with others may offer uniquely important informational and emotional support resources that buffer the impact of a functional impairment on well-being (Silverman et al., 2017).

Finally, psychologists working with clients with disabilities over time need to remain cognizant that interventions may require re-evaluation as the client's disability experience and adaptive skills change and the psychologist gains new disability specific knowledge that may enhance service provision.

GUIDELINE 21

Psychologists strive to honor the experience of disability in the development of the therapeutic relationship.

Potential therapeutic outcomes depend not only on a realistic intervention plan within which to address goals, but also on the development of a successful therapeutic relationship. This relationship reflects the psychologist's ability to understand and respond sensitively to the individual's (and family's) emotional reactions and perspectives on the meaning of disability. Similar to working with other individuals seeking psychological services, the psychologist recognizes that each person responds uniquely to their individual circumstances and to intervention.

Psychologists working with people with disabilities are encouraged to be mindful of the cognitive and emotional symptoms that may arise. Some individuals may experience an emotion, work through it, and then return to it later (Smart, 2001). Others may experience emotional reactions for which they do not follow a simple linear sequence toward adaptation after a disabling injury occurs (Livneh & Martz, 2012). For people with disabilities, talking about their disabilities may be complicated. Some people with disabilities may be anxious and worried about being judged when sharing stories of their disabilities and traumas, whereas others may prefer to draw strength and purpose from telling their stories of triumph over adversity, dispelling myths about disability, or advocating for better disability policies and political power for disabled people. Given the mixed cognitive and psychological reactions and emotions about sharing disability experiences with others, psychologists providing a positive, supportive response to individual disability stories can be validating. Research has also supported the concept that hope and positive disability identity contribute to overall well-being (Zapata, 2020), so creating a safe space for clients to share disability experiences toward positive identity development may be an important aspect of the therapeutic relationship and intervention plan. In addition, showing genuine empathy may strengthen the working alliance by reducing misunderstandings and judgment. A few small studies have noted the importance of the psychologist's characteristics and approach (e.g., empathy and disability knowledge) rather than the specific techniques used in supporting a positively perceived experience with intervention by individuals or parents of individuals with disabilities (Hampton, Zhu, & Ordway, 2011; Pert et al., 2013; Schreiber et al., 2011).

Acknowledging one's life circumstances (e.g., social support, income level), personality characteristics (e.g., optimism, hope, emotional reserves), and the interaction between disability and environment (e.g., the ability to return to work, legal issues, response to sociopolitical climate) are all potential considerations in assessing the person's response to disability as the psychologist develops a therapeutic relationship and designs and adapts responsive, appropriate interventions (Dunn, 2019; Elliott et al., 2002; Kennedy et al., 2000; Kortte & Wegener, 2004; Turner and Bombardier, 2019).

Finally, it is important for psychologists to recognize that although the disability experience is a common reason for seeking psychological services, many people with disabilities seek services for other reasons. Some clients may want psychological support to enhance their quality of life by improving their relationships, making career choices, or exploring new learning opportunities or enhancing their lived experience in other ways. Like everyone else, individuals with disabilities have unique strengths (e.g., Shogren et al., 2006). Personal strengths can include education, personality traits, self-advocacy, creativity and talent, social relationships, and access to necessary supports. Psychologists can strengthen the therapeutic relationship by recognizing the client's strengths, which, in turn, can lead to more positive outcomes. Interventions that consider the personal strengths of a disabled client have been shown to increase the individual's self-worth, empowerment, and resilience to deal with life's issues (Dunn & Dougherty, 2005; Dykens, 2006; Olkin, 2012). Further, the concept of resilience has been found easily integrated within a broad range of clinical work and intervention (Ten Hove & Rosenblum, 2018). Readers are referred to Amtmann et al. (2020) for a resilience item bank.

GUIDELINE 22

Psychologists strive to collaborate with other professionals and stakeholders across systems to facilitate clients' self-determination, informed choice, and social inclusion.

For individuals who have a disability, health or mental health condition requiring intervention and supports, psychology may offer important contributions to understanding, explaining, predicting, providing support, and advocacy. Significant contributions by the psychologist are made in a collaborative process with other professionals and stakeholders in the individual's biopsychosocial system. As noted throughout this document, the system may involve the individual; family; health professionals; community; educators and educational, vocational and legal systems; and other professionals. In this context, the psychologist's contributions are likely shared within a multi- or interdisciplinary group. Many community agencies and systems influence the lives and psychological well-being of individuals with disabilities and their families (Heinemann, 2005; Hernandez et al., 2006). Psychologists who work with organizations and/or systems that support and serve individuals with disabilities should strive to keep the clients' needs and perspectives paramount. Advocating with individuals with disabilities may also draw attention to the need for reform in various systems (e.g., educational, vocational, criminal justice). Many people with disabilities have faced barriers to quality education, employment opportunities, and mental health services, yet these factors are often not considered holistically by professionals and/or providers. Psychologists are encouraged to work with different systems to raise disability awareness, promote social inclusion, and advocate for supports and services more accessible to clients with disabilities. This may involve consulting with individuals, families, and support groups; working collaboratively with teams and organizations; and creating beneficial adaptations and accommodations as well as enabling environments.

In addition to considering a Biopsychosocial framework, it is recommended that psychologists consider Ecological Systems Theory (Bronfenbrenner,1995) when working with people with disabilities. While conceptualized as a way to understand facets of child development, this theory remains applicable throughout the life span in that individuals continuously experience their lives within distinct yet overlapping systems. These systems are defined as **Microsystem:** institutions or systems that directly affect or impact an individual in a single, immediate setting: *family, school, friends, church or synagogue groups, disability support groups*; **Mesosystem:** interaction between two or more settings in which an individual actively participates: *interaction between home and school/work and medical/health care settings*; **Exosystem:** settings where the individual may not actively participate, yet events occurring have the potential to impact them, such as *economic systems, healthcare systems, education systems, and legal systems*; **Macrosystem:** widely shared systems: *cultural beliefs, norms, laws and policies, values, customs*; **Chronosystem:** how these systems are experienced through time: *changes in the ways the mesosystem is experienced over time, changes in the microsystem throughout the life span.*

The ecological micro, meso, exo, and macro systems provide a lens to understand not only the ecological systems that individuals with disabilities operate within, but also the ways those systems overlap and intersect. Psychologists may advocate for persons with disabilities and family members to share their lived experience and perspectives as stakeholders and/or by participating in disability agency leadership roles. Psychologists may also support the aspirations of individuals with disabilities by appropriately involving each individual in intervention, educational, vocational, and life-care planning, and by emphasizing self-determination and participation in decision-making processes (Gill et al., 2003). Additionally, psychologists may possess expertise to provide organizational consultation and skills training to advocacy/support groups for individuals with disabilities who are eager to advocate for social change (Hernandez et al., 2006).

In the school context, psychologists working with adolescent students who have intellectual or learning disabilities should strive to involve the student and family in developing an IEP and making informed life choices (Combes, Hardy, & Buchan, 2004). To promote person-centered planning and making informed choices, psychologists also work with other professionals/service providers in schools to determine preferences and needs of individuals with disabilities. Similarly, in an employment context, psychologists may work with employers/human resources personnel and assist companies in developing disability awareness training for other employers, incorporating inclusive hiring practices, and building a management foundation that understands and motivates employees, and helping staff embrace the company's mission in disability inclusion. To that end, psychologists may work with disability service systems or support social networks to maximize disabled individuals' involvement in all appropriate decisions and ensure they receive appropriate services.

In addition to educational and employment settings, several general roles exist for psychologists in the legal system (Bottoms et al., 2004). Some psychologists are involved in evaluating the success of various legal interventions or reforms (e.g., the effectiveness of drug courts in reducing recidivism by emphasizing treatment and supervision rather than incarceration; Winick, 2003). According to a Bureau of Justice Statistics report, the rate of disability among those who have been incarcerated is significantly higher than in the general population—with 32% of those in prison and 40% of those in jail reporting at least one disability (Bronson et al., 2015). Two in 10 people in prison and 3 in 10 in jail reported having a cognitive disability. Psychologists may work with criminal justice systems to recommend changes to improve accessibility for those with disabilities. Examples include recommending installing ramps to allow those with physical disabilities to have easier access to outdoor recreation areas that usually are a step higher than the surrounding floor; providing technology to allow Deaf inmates to communicate within the prison or with those outside the prison; and ensuring therapy, religious services, and classes inside the jail are accessible.

One final group psychologists may work with are students. Understanding disability is clearly an important component of training. Psychology supervisors are critical to helping students embrace the Ethical Standards, which require awareness of and respect for individuals with disabilities with whom students work. Students cannot effectively meet the Ethical Standards without appropriate professional knowledge, skills, and self-reflection regarding attitudes and behavior toward people with disabilities. Conversely, psychologists who are educating students need to model inclusive practice. Such teaching includes removing barriers for students with disabilities to participate in all aspects of training. Although a paucity of data exists on the experience of psychology trainees with disabilities, the little research available suggests that there is both underrepresentation of disabled students in psychology graduate programs and that students with disabilities encounter misassumptions about capabilities and barriers to training, including internships (Andrews et al., 2013; Andrews & Lund, 2015). Additionally, research shows that psychology trainees with disabilities often report experiencing disability-related discrimination and benefit from mentorship from psychologists with disabilities (Lund et al., 2014; Lund et al., 2021). The field has called for the importance of culturally competent supervision for trainees with disabilities (Andrews et al., 2013), as stigma, bias, misinterpretations, or assumptions related to disability occur among some supervisors (Pearlstein & Soyster, 2019). Andrews et al. (2015) provide recommendations for culturally competent supervision. Psychology training programs are encouraged to integrate these guidelines into training of future psychologists. Lastly, psychologists may work with other team members and community agency collaborators to advocate for appropriate student access and reasonable accommodations as part of culturally sensitive, inclusive practice.

GUIDELINE 23

Psychologists strive to recognize the importance of health promotion and facilitate implementation and maintenance of healthy behaviors by individuals with disabilities.

Psychologists recognize that disability is not synonymous with disease or illness (Ravesloot et al., 2011). In fact, individuals with disabilities often lead healthy and independent lives, but experience more preventable and/or manageable secondary health conditions that may affect their financial status and employment, psychosocial health and well-being, and participation in community life (January et al., 2015; Karpur & Bruyere, 2012; Kinne, Patrick, & Doyle, 2004; Ravesloot, Seekins, & White, 2005; WHO, 2001). An unhealthy lifestyle also increases the risk for developing conditions associated with disability, such as stroke (Chiuve et al., 2008).

Recent research has found that people with disabilities who report engaging in adverse health behaviors (e.g., lack of exercise, insufficient sleep, smoking) report more mental distress than people with disabilities who do not report these behaviors (Cree et al., 2020). This is particularly problematic given that mental distress has been reported to be over four times more likely in individuals with disabilities compared with those without disabilities (Cree et al., 2020). Additionally, risk factors for secondary complications, such as obesity and diabetes, may be compounded by other minority identities, including race, ethnicity, and socioeconomic status/poverty (Anderson et al., 2013; Courtney-Long et al., 2017). On the other hand, engagement in constructive health behaviors by individuals with disabilities, such as through health promotion programs, has been linked to decreased secondary complications and health care costs and improved behavioral health, attention, and well-being (Anderson et al., 2013; Chan et al., 2012; Ferraz et al., 2018; Heller, Fisher, Marks, & Hsieh, 2014; Ginis et al., 2010, 2013; Ravesloot et al., 2016). Some research also suggests that positive health behavior (exercise), when combined with other intervention (cognitive training), has an additive effect on cognitive and motor function (Yeh, Chang, & Wu, 2019).

Given that physical and mental health are intimately related, psychologists may assist clients with disabilities in understanding how maintaining health and preventing secondary conditions may help them achieve life goals. As Eagle et al. (2017) note, “health promotion interventions have the potential to improve secondary physical health and mental health conditions, work performance, and health-related quality of life for people with chronic illness and disability” (p. 108).

Numerous health promotion models exist that psychologists might consider to address health behaviors with people with disabilities. Several of these have been reviewed by Eagle et al. (2017) as well as reviewed or applied to specific disability groups by others (Chiu et al., 2011; Ginis et al., 2013; Ipsen et al., 2012; Keegan et al., 2012; Turner & Bombardier, 2019). Eagle et al. (2017) note that these health promotion models share two key components: self-efficacy (perceived skills, resources, and ability to engage in healthy behavior) and outcome expectancy (perceived benefits and risks of engaging in healthy behavior). Self-efficacy and outcome expectancy are also primary components of health behavior change theories (Ravesloot et al., 2011). Eagle et al. (2017) also emphasize the importance of the client having access to and processing appropriate health information and engaging in goal setting as precursors to creating positive change. Psychologists may facilitate these components as part of health promotion interventions. They can help their clients (1) understand the beneficial relationship between health and well-being, (2) discuss the client’s perceived skills and resources, (3) evaluate their readiness for change, (4) anticipate potential barriers to change, (5) work collaboratively on a health promotion plan that includes concrete goals and actions, (6) encourage steps towards engagement, and (7) reinforce healthy lifestyle practice and maintenance that prevent both primary and secondary health problems (Gill & Brown, 2002; Heller, Hsieh, & Rimmer, 2002; Heller & Marks, 2002). Depending upon availability, psychologists may also refer clients to organizations providing structured health promotion programs, such as the Living Well with Disability program offered in multiple states through a partnership with the national network of Centers for Independent Living (Ravesloot et al., 2016).

There are several national organizations that address health promotion for people with disabilities. The National Center on Health, Physical Activity, and Disability (https://cdc.gov/ncbddd/disabilityandhealth/national-programs.html) works collaboratively with the Centers for Disease Control and Prevention (CDC) to offer resources on disability and healthy living for both professionals and people with disabilities and their families. The CDC also lists CDC-funded state disability and health programs and houses the Disability and Health Data System that allows users to search key health indicators by state (https://cdc.gov/ncbddd/disabilityandhealth/healthyliving.html).

Since the Surgeon General’s *Call to Action to Improve the Health and Wellness of Persons with Disabilities* (Carmona et al., 2010; Office of the Surgeon General, 2005), significant progress has been made promoting healthy living for people with disabilities. However, many barriers still exist affecting practice processes and outcomes as discussed in earlier guidelines in this document (Anderson et al., 2013). The Healthy People 2030 initiative has as one of its overarching goals to promote healthy development, healthy behaviors, and well-being across all life stages. Psychologists, through both practice and advocacy, have much to contribute to support the health and well-being of individuals with disabilities. Perhaps one of the most important roles is empowering people with disabilities.

CONCLUDING STATEMENTS

The *Guidelines for Assessment and Intervention with Persons with Disabilities* are recommendations that psychologists are encouraged to implement to strengthen their professional knowledge and skills in advancing the health and well-being of disabled individuals. It is a living document that will evolve as research, practice, and training advance. These *Guidelines* are based on the belief that disability is part of the rich diversity of our society. To that end, the *Guidelines* reflect several key points.

First, psychologists are uniquely positioned to work with individuals with disabilities and other stakeholders to facilitate disabled individuals' health and well-being, and to promote their full inclusion in our society. Second, psychologists may enhance their professional skills and ensure validity, fairness, and appropriateness of assessments and interventions by critically evaluating their own possible biases and stereotypes about disability. Third, psychologists strive to recognize that the disability experience is multifaceted and may be affected by different intersections and sociocultural contexts that may require exploration. Fourth, psychologists strive to recognize that not all clients seek clinical services based on disability-related issues. Psychologists can help individuals discover and balance personal strengths and challenges. Fifth, psychologists strive to promote equal access and opportunity for persons with disabilities by using all appropriate accommodations in their procedures and practices and by guarding against construct irrelevant factors affecting valid, fair assessments and interventions. Finally, psychologists may actively pursue disability-related training, education, and consultation with psychologists, other health professionals, and community service providers who have expertise in working with individuals with disabilities to maintain and strengthen their skills and knowledge to serve their clients competently and ethically. With these strengths, psychologists have the opportunity to be effective advocates for change that removes individual and systemic barriers and contributes to a more inclusive society.

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RESOURCE GUIDE

American Academy of Pediatrics Healthy Children
healthychildren.org

American Association on Intellectual
and Developmental Disabilities
aaidd.org

American Burn Association
ameriburn.org

American College of Rheumatology
rheumatology.org

American Diabetes Association
diabetes.org

American Foundation for the Blind
afb.org

American Printing House
aph.org

Amputee Coalition
amputee-coalition.org

Association of University Centers on Disabilities
aucd.org

Brain Injury Association of America
biausa.org

Centers for Disease Control and Prevention
cdc.gov

Center for Excellence in Universal Design
universaldesign.ie

Christopher & Dana Reeve Foundation
christopherreeve.org

Epilepsy Foundation
epilepsy.com

iAccessibility.com
iaccessibility.com

Job Accommodation Network
askjan.org

Mayo Clinic
mayoclinic.org

National Association of the Deaf
nad.org

National Cancer Institute
cancer.gov

National Center for Post-Traumatic Stress Disorder
ptsd.va.gov

National Federation of the Blind
nfb.org

National Institute of Arthritis and Musculoskeletal
and Skin Diseases
niams.nih.gov

National Institute on Drug Abuse
drugabuse.gov

National Institute of Mental Health
nimh.nih.gov

National Multiple Sclerosis Society
nationalmssociety.org

National Institute of Neurological Disorders
ninds.nih.gov

National Spinal Cord Injury Statistical Center
nscisc.uab.edu

Substance Abuse and Mental Health Services Administration
samhsa.gov

The Arc
thearc.org

United Cerebral Palsy
ucp.org

World Health Organization
who.int

Adaptive Sports

Athletics for All
athleticsforall.net

Challenged Athletes Foundation
challengedathletes.org

Move United
moveunitedsports.org

U.S. Olympic and Paralympic Committee
teamusa.orgTeam-USA-Athlete-Services/Paralympic-Sport-Development

National Center on Health, Physical Activity and Disability
nchpad.org

Paralyzed Veterans of America
pva.org

Special Olympics
specialolympics.org

In addition to the APA, its divisions, and the resources listed above, all of the following organizations provide free webinars and resource information. This is a sampling of a broad range of resources now available electronically.

Alzheimer's Association
alz.org

American Congress of Rehabilitation Medicine (ACRM)
Archived Webinars
acrm.orgresources/video-library/

Autism Self Advocacy Network
autisticadvocacy.org

American Society on Aging
asaging.org

Brain Injury Alliance of Iowa Archived Webinars
youtube.com/channel/UChA-bLo-2EGMJlJScPuoTzA/videos

Brain Injury Association of America Butch
Alterman Memorial Webinars
bit.ly/3v0AHnt

Craig Hospital brain and spinal cord injury resources
craighospital.org

Facing Disability.com for families facing spinal cord injuries
Facingdisability.com

Family Caregiver Alliance
caregiver.org

National Deaf Center on Postsecondary Outcomes
learn.nationaldeafcenter.org

National Paralysis Resource Center
christopherreeve.orgliving-with-paralysis/about-the-paralysis-resource-center

Shepherd Center Brain Injury and Spinal
Cord Injury/ Dysfunction Webinars
bit.ly/36oiFBA

Tourette's Association of America Webinar Series
tourette.orgresources/taa-webinars/

Parkinson's Foundation
parkinson.orgpd-library

Uniformed Services University, Center for Deployment Psychology
deploymentpsych.org

US Department of Veterans Affairs
research.va.gov

Epilepsy Centers of Excellence
epilepsy.va.gov/Provider_Education.asp

Spinal Cord Injuries and Disorders System of Care
sci.va.gov/VAs_SCID_System_of_Care.asp

Traumatic Brain Injury
research.va.gov/topics/tbi.cfm

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