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Gender is a key, salient identity that influences every individual as society has gendered expectations for men and women. Society currently constructs gender as rigid categories of male and female. While men are expected to be masculine, strong, assertive, dominant, and independent, women are assumed to be caregivers, vulnerable, weak, passive, and emotional (Mahalik, Good, & Englar-Carlson, 2003; Hirschmann, 2012). Gender is currently a large topic in psychological research as gender interacts with an individual’s other identities including sexual orientation, race, and mental health status.

However, little research focuses on the intersection between gender and disability even though the gender of an individual with a disability predicts mental health outcomes and experiences in counseling. A content analysis exposes a dearth of research on disability as only 1% to 2.7% of the current literature in counseling psychology examines issues related to disability (Foley-Nicpon & Lee, 2012). This lack of research is alarming as people with disabilities constitute the largest minority group in America. The 2010 US Census estimates that 56.7 million people, around 18.7% of the US population, have some form of disability (Brault, 2012). Other estimates are even higher as definitions of disability vary across studies. Although exact definitions of disability vary, the term “disability” is typically defined as a physical or mental impairment that limits or restricts an individual’s ability to perform activities typical of daily living (Beecher, Rabe, & Wilder, 2004; Brault, 2012). For example, people with disabilities might have difficulties with daily hygiene, movement, seeing, hearing, working, or learning. Despite this wide range of experiences with disability, many individuals speak of disability as a
culture and a key uniting identity. Disability spans across all identities as it affects all races, classes, ethnicities, religions, sexual orientations, and genders.

People with disabilities would benefit from mental health services because they face immense stigmatization from society and are at an increased risk for numerous mental disorders, especially depression and anxiety (Hee-Ju Kang et al., 2015). One study estimates that people with physical disabilities are 2-3 times more likely to have depression than those without physical disabilities (Hee-Ju Kang et al., 2015). A woman with a disability is at an even higher risk of having depression or anxiety than her male counterpart (Hee-Ju Kang et al., 2015). Psychologists should be prepared to work with clients with disabilities as there is a significant intersection between mental illness and disability.

Despite this need for clinician’s awareness of the gendered effects of disability on mental health, disability has been historically ignored in psychological research and training. Most of the existing research on gender and disability is confined to feminist studies, sociology, and disability studies. There is a lack of training for psychologists to address the specific needs of individuals with disabilities, which leaves many psychologists feeling unprepared. There is also a lack of self-assessment tools for counselors to evaluate their own biases towards individuals with disabilities (Foley-Nicpon & Lee, 2012). This could lead counselors to unknowingly perpetuate stereotypes about people with disabilities. As psychologists seek to become more aware of their clients’ unique identities, understanding the specific needs of their male and female clients with disabilities is vital.

In this review, I will explore the intersection between gender and disability in a clinical setting. I will focus specifically on physical disabilities rather than cognitive or developmental disabilities. I will first discuss the history of studying disability as disability is typically studied
in an academic setting through the perspectives of the medical model, feminist model, social model, and disability studies. Finally, I will discuss the current literature in psychology, emphasizing the need to draw from other perspectives. After examining the historical background, I will explore the intersection between gender and disability, detailing the common perceptions of people with disabilities and the specific needs of men and women with disabilities. In this section, I will consider the relationship between disability and gender socialization, gender roles, masculinity, femininity, and motherhood. Finally, I will explore the roles of psychologists in treating their clients with physical disabilities and how they can take their client’s unique intersecting identities into consideration to avoid perpetuating stereotypes about disability.

To narrow the scope of this study, articles focusing on intellectual or cognitive disabilities and aging populations have been excluded from review. People with intellectual and cognitive disabilities face different stereotypes and stigmas than people with physical disabilities, which would complicate this study. This population deserves an additional, in-depth review as their agency is called into question. The elderly population is at a higher risk of developing disabilities and must also adjust to losing independence as they age. Separate review would be necessary to address the specific needs of elderly people with disabilities and individuals with cognitive or intellectual disabilities.

**Models of Disability**

In order to understand the psychological study of disability, a history of the main models used to examine disability is necessary. I will begin by discussing the medical model of disability that dominated society’s perspective of people with physical disabilities. Starting in the 1980s, third-wave feminists began to study disability, demanding that multiple identities such as race,
ethnicity, sexual orientation, and disability be included in feminist discussions. Much of the current research resides in sociology and focuses on stigma and stereotypes against people with disabilities. In the early 2000s, disability studies became a recognized field of study. Disability studies focuses on disability as a culture and brings together multiple disciplines. In the past few decades, the study of disability has become a small but growing topic in psychology.

**The Medical Model of Disability**

The medical model of disability was pervasive throughout the 20th century and continues to be a popular perspective of disability today. From this model, disability is studied as a biological deficiency that must be treated or remedied through medical advancements (Foley-Nicpon & Lee, 2012). The goal of the medical model of disability is to diagnose pathology and bring the disabled body closer to a “normal” body (Foley-Nicpon & Lee, 2012). Although this model encourages the development of medicine and technology that can assist individuals with physical disabilities, the medical model of disability implies that the disabled body is biologically inferior and it promotes a narrow view of an ideal body (Foley-Nicpon & Lee, 2012). This model heavily focuses on individual limitations rather than societal factors of disability such as the inaccessibility of buildings or stigmas against people with disabilities (Scullion, 2010; Smart & Smart, 2006). Under this view, the individual with a disability needs to conform to society rather than society changing to accommodate an individual with a disability. The medical model marks disability as a personal problem rather than a societal issue and equates biological difference with defect. For example, if an individual is injured and no longer able to walk, someone working from the medical model of disability would focus on rehabilitation and enabling the person to gain as much functioning as possible rather than
focusing on the inaccessibility of many buildings or society’s views towards people who cannot walk.

Within the health services, the medical model of disability remains a popular mode of conceptualizing disability (Scullion, 2010). This model is useful in mitigating pain and can lead to medical and technological innovations that could improve the quality of life for people with disabilities. However, a medical mindset might lead a psychologist to focus solely on the client’s disability, assuming mental health can only improve when the physical disability is remedied or mitigated (Nathanson, 1979). A psychologist working solely from the medical mindset might assume that their client is seeking mental health services because of their disability. In addition, this perspective might lead the psychologist to focus on identifying personal deficits rather than recognizing the individual’s strengths and society’s stigma against people with disabilities. Some argue that an exclusive focus on the medical model is responsible for the discrimination that people with disabilities face (Scullion, 2010). It is crucial that psychologists understand the dangers of working solely from a medical model of disability.

The Feminist Model of Disability

The feminist model of disability stands in stark opposition to the medical model of disability by emphasizing the social factors of disability instead of physical limitations. The first theories about disability and gender stem from feminist studies (Shuttleworth, Wedgwood, & Wilson, 2012). During the conceptualization of the third wave of feminism in the late 80s, feminists began to argue that people with disabilities need to be included in discussions of equality. Third-wave feminists criticized their predecessors from the second-wave for focusing on white-heterosexual, able-bodied narratives (Hirschmann, 2012). Feminists with disabilities
felt as if they were rejected from the feminist movement and emphasized the importance of addressing multiple oppressed identities.

The third-wave feminist movement focuses on shared or common experiences of disability and the added oppression that women with disabilities face compared to their able-bodied peers (Rohmer, 2009). Feminists propose that being disabled has different effects based on gender due to differences in socialization and gender expectations. Research on disability, specifically the intersection between female gender expectations and disability, increased due to this movement. Although the movement was popular in the 80s and 90s, feminists continue to discuss the intersection of gender and disability today as it relates to gender identity and sexual orientation. Psychologists studying the feminist perspective of disability would recognize the importance of considering multiple identities such as sexual orientation, race, socioeconomic status, and gender in discussions of disability.

**Social Models of Disability**

Under a social or sociological model, disability is a social construct that communicates ideals of the human body (Samuels, 2014). While many people think of disability as an unquestionable, easily identifiable category, sociologists argue that disability is a created concept. They point to the variability in definitions of disability to support this claim. In the past, women, people belonging to minorities, individuals with physical abnormalities, and people who are intellectually disabled have all been pathologized in order to justify the mistreatment of these groups. Sociologists emphasize that disability is not inherent in the individual but rather defined by society (Hirschmann, 2012). Labeling someone as “disabled” promotes ideals of normality of the human body. Those in control of the label of disability are in control of social perceptions of disability and they create a hierarchy of individuals in society.
Sociological perspectives also explain individual reactions to disability based on stereotypes about people with disabilities. From a sociological lens, people with disabilities are seen as lesser citizens, especially if they cannot contribute to society in normative ways (Parker, 2015). People with physical disabilities are typically viewed as helpless, weak, effeminate, and asexual (Nathanson, 1979). People often assess an individual’s limitations and make judgments about that individual’s character based on their perceived abilities (Samuels, 2014). These stereotypes heavily impact individuals with disabilities as they have to combat these assumptions and discrimination.

From a sociological standpoint, people also often distance themselves from those with disabilities, feeling disgust, pity, overprotection, or nervousness. According to the theory of terror management, disability makes people uncomfortable because it reminds them of the variability of the human body (Hirschberger, Florian; Mikulincer, 2005). Disability makes people recognize that their physical body and personal identities can change suddenly (Hirschmann, 2012). It is easier to ignore people with disabilities than acknowledge that anyone can suddenly become disabled from an accident or illness. From this view, people distance themselves from disability because it challenges their own self-perceptions.

According to all sociological models of disability, disability is a social construct and increasing the well-being of people who are disabled hinges on changing society’s perception of disability. The social models of disability focus on the barriers that prevent people with disabilities from participating in common activities. A sociologist might focus on the inaccessibility of building or discrimination against people with disabilities as the cause of pathology of some people who are disabled (Scullion, 2009). While these models address the larger, societal influences on depression, they often ignore the pain that many individuals living
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with physical disabilities face and the potential for medicine and surgery to improve quality of life for some individuals with disabilities.

The social model of disability emphasizes the need for psychologists to investigate their implicit biases and orientation towards disability. By placing the problem in society’s view of disability, it encourages psychologists to take a more active role in the community in addressing stereotypes and stigmas.

Disability Studies

Disability studies focuses on disability as a culture and identity. Although disability studies began in the 1980s, it was not recognized as an established field of study until Modern Language Association recognized it as legitimate in 2005 (Davis, 2006). In disability studies, physical or intellectual impairment is separated from the culture of disability. This field draws heavily from feminist and social perspectives as disability is considered a social construct.

Disability studies values personal experiences. Many of the major contributors to this field become interested in disabilities due to personal experience with disability. They also stress the importance of personal testimony as a means for social change. Psychologists interested in disability studies would recognize the importance of multidisciplinary research and addressing unique experiences of people with disabilities.

The Study of Disability in Psychology

In the past few decades, disability has entered psychological literature. People with disabilities are more likely to have mental health disorders so it is imperative that psychologists develop theories and treatments for individuals with mental illness and physical disabilities (Brown, 2014; Shuttleworth, Wedgwood, & Wilson, 2012; & Robertson, 2014). The topic of disability in this literature is typically discussed within the realm of multicultural psychology as
disability intersects with clients’ multiple identities. For example, women with disabilities are much more likely to experience depression than their male counterparts and women without disabilities (Brown, 2014). Men, on the other hand, are more likely to express concerns about maintaining their strength and previous self-perceptions (Shuttleworth, Wedgwood, & Wilson, 2012). Therefore, experiences of disability and a therapist’s approach may vary based on the client’s other important identities such as gender. However, there are few studies on the intersection between gender and disability in counseling psychology. Even fewer studies give concrete suggestions for psychologists in counseling individuals with disabilities.

One study that offers a model for counselors is Lewis’ “Three Factor Model” (2006). The first step in this model is to assess the client’s current developmental stage. In this stage, the therapist assesses their client’s current cognitive and intellectual development. In the second stage, the psychologist evaluates how closely their client identifies with their culture and that culture’s assumptions about gender and disability. Lastly, the therapist and the client determine their goals for the client’s adjustment to disability.

In addition to these three main goals, Lewis suggests that psychologists assess their own awareness of their culture’s assumptions about disability and their own confidence in helping individuals with disabilities (2006). Implicit in the model are the importance of understanding multiple identities, a personal relationship between therapist and client, and awareness of the client’s best interests (Lewis, 2006). The Three Factor Model could be used as a base for creating self-inventories for psychologists and intake forms for clients. However, few psychological articles give concrete suggestions like Lewis.
Men with Disabilities

Although each individual’s experience with disability is unique, research has shown that, because of gender socialization and society’s differing expectations for men and women, there are many shared experience of men with disabilities that differ from women’s experiences with disability. Pressure to be masculine, assumptions of asexuality despite the masculine script of sexual assertiveness, and reliance on self-assessments and mastery are unique to men with disabilities. In order to effectively treat men with disabilities, psychologists should inform themselves of these particular concerns for men and incorporate this knowledge into their therapy practices.

Most of the discourse on men’s experience with disability focuses on the conflict between masculinity and disability. Men are socialized to be masculine, which includes a variety of scripts including pressure to be strong and silent, tough, aggressive and violent, sexually assertive, homophobic, competitive and successful, and independent (Mahalik, Good, & Englar-Carlson, 2003). Multiple studies note that these masculine ideals are in direct conflict with the stereotypes that people with disabilities are effeminate, weak, helpless, and asexual (Brown, 2014; Shakespeare, 1999; Shuttleworth, Wedgwood, & Wilson, 2012). Visually apparent disabilities are typically one of the first identities that participants noticed in one study above gender and race (Rohmer & Louvet, 2009). This means that, although men with disabilities might place more importance on their other identities or their masculinity, society sees them as helpless and effeminate first.

Gerschick and Miller (1995) propose a “Three R Framework” to describe the reactions men can have towards masculinity. Under this framework, men who develop disabilities can either rely on, reformulate, or reject traditional masculine scrips. If a man with a disability relies
on traditional masculinity, he has internalized masculinity scripts and feels the divide between disability stereotypes and masculinity the most. This reliance is associated with the worst mental health outcomes, especially higher rates of depression (Gerschick & Miller, 1995). Men can also reformulate their concept of masculinity to be compatible with disability. For example, a man who reformulates masculinity might hold onto the values of competitiveness and aggressiveness and join an adaptive sports team for individuals with disabilities. Finally, men can also reject masculine or gender roles altogether by forming their own value system. Under this model, if a man with a disability rejects or reforms society’s views of masculinity, his mental health and identity are typically more stable than men who internalize masculine ideals. As Hirschmann (2012) and Gibbs (2005) demonstrate, this framework can be useful in describing men’s reactions to a wide variety of physical disabilities.

Men with disabilities are also presumed to be asexual although they have the same desires as the general population (Shuttleworth, 2004). Men with disabilities, especially visual physical disabilities, are assumed to be incapable or uninterested in sexual activity (Esmail, Darry, Walter, & Knupp, 2010). Most sexual education classes do not discuss disability and sexual activity so people have little exposure to this topic and these assumptions are not challenged (Esmail, Darry, Walter, & Knupp, 2010). This misconception about disability may lead to relationship trouble as men with disabilities may not be seen as potential romantic and sexual partners. If men are pressured into being masculine but society focuses on their disability as it is a more salient identity, mental health outcomes are poorer (Shuttleworth, 2004 & Rohmer & Louvet, 2009). The assumption of asexuality of men with disabilities is in direct conflict with the masculine script of sexual aggressiveness. Men with disabilities who are consistently rejected
or internalize these asexuality stereotypes have lower-confidence and worse mental health (Esmail, Darry, Walter, & Knupp, 2010).

Finally, the last main concern specific to men with disabilities involves the typical response of a man who develops a disability. As noted by Brown (2014), men focus heavily on self-assessments and mastery in dealing with disability rather than focusing on relationship changes. Mastery refers to the extent to which one feels in control of his circumstances. Appraisal of one’s own abilities and a sense of control is especially important for men with physical disabilities in predicting symptoms of depression (Brown, 2014). This especially important for men who become disabled later in life as they may feel a loss in control over their lives and shift in their sense of ability. As men who develop disabilities later in life seek to reform their identities, psychologists could focus on individual and intellectual strengths during counseling, especially if the men feel as if they have lost control and self-efficacy.

**Practical Implications for Men with Disabilities**

In assessing a male client with a disability, a psychologist should evaluate the man’s relationship to masculinity. If the individual ascribes to typical views of masculinity, his mental health is typically worse as he struggles to maintain his masculinity despite stereotypes against people with disabilities (Shuttleworth, 2004). Psychologists can help their male clients critically asses their orientation towards masculinity. A therapist should not force their client to reform or reject masculinity, but they should be willing to explore the effects masculine ideals on their male clients. Psychologists cannot ignore their client’s relationships in therapy or assume that sexuality is not important to clients with disabilities. On an intake form, the therapist could ask their male clients for a relationship background and explore their desire to be in a relationship and society’s perception that men with disabilities are asexual. Counselors should be able to
point their male clients with disabilities towards social support systems. Finally, therapists should focus on building mastery and self-efficacy with their male clients. A psychologist could help their male clients redefine their identities around their personal skills rather than focus on a loss of control.

**Women with Disabilities**

Although the study of gender and disability stems from feminist studies, currently most of the research in psychology focuses on men with disabilities, specifically masculinity and disability. Most of the discourse on women’s experience with disability focuses on the compounded oppression from society based on gender and disability stereotypes. The stereotype that women are emotional affects women with disabilities as their physical pain is often assumed to be psychosomatic. Finally, while men focus on self-assessment and mastery in adjusting to disability, women tend to focus on relationship changes. In order to effectively treat women with disabilities, psychologists should inform themselves of these particular concerns for women and incorporate this knowledge into their therapy practices.

Most research notes that having a disability and being a woman are associated with helplessness, vulnerability, weakness, incapability, passivity (Hirschman, 2012; Brown, 2014; Shakespeare, 1999). Women with disabilities are viewed as an especially vulnerable and helpless population that needs to be safeguarded and protected. They are typically viewed as passive victims of disability. The more oppressed identities the woman has, the more society assumes she is weak and vulnerable. It is especially difficult for health professionals to avoid these stereotypes as research demonstrates that women with disabilities are at an increased risk for poverty and for physical and sexual abuse than women without disabilities (Barrett, O’Day, Roche, & Carlson, 2009). While women with disabilities are often assumed to be asexual just
like men with disabilities, they are also often fetishized. While women with disabilities are at an increased risk of being taken advantage of physically and sexually, psychologists should be careful not to belittle their female clients or take pity.

The experiences of women with disabilities are often minimized as their physical pain is often ignored. The pain a woman experiences in having a chronic illness or disability is often attributed to emotional problems rather than physical discomfort as women are typically viewed as more emotional than men (Hirschmann, 2012). Women with disabilities are more likely to report unmet health care needs than men, especially if they are abused (Barrett, O’Day, Roche, & Carlson, 2009). Gender socialization encourages women to focus on emotions and women are stereotyped as more emotionally unstable than men. This means that the physical pain a woman experiences may be mistreated as a mental problem when the actual source can be treated physically (Hirschmann, 2012). The complaints of women with disabilities are often distorted and misunderstood.

As noted by Brown (2015), women focus heavily on the impact that disability has on their relationships with others. He suggests that women with disabilities face more psychological problems as they do not rely on self-esteem and mastery as much as men and instead focus on emotional connection and reliance. Women may feel unstable in their relationships after developing a disability as they are no longer able to care for friends and family in the way they have been socialized to. Women with physical disabilities express fears about pregnancy and raising a child with their disability (Shandra, Hogan, & Short, 2014). They are as equal as women with disabilities to want to have children but less likely to have children (Shandra, Hogan, & Short, 2014). Women are expected to take on caregiving roles but people assume that they are severely restricted by their disability. The identity of being a mother and an individual
with a disability are seen as conflicting by general society (Robertson, 2014). Since mothers are typically placed in the role of primary care-giver, more scrutiny lies on mothers with disabilities than fathers with disabilities. A woman’s insecurities about her relationships after developing a disability are exacerbated by society’s assumption that people with disabilities are helpless and require lots of care. Social support is especially important for women with disabilities.

**Practical Implications for Women with Disabilities**

Before working with a female client with a disability, psychologists should ask themselves if they typically view women with disabilities as passive and vulnerable. Psychologists should also be careful not to ignore their client’s complaints of physical pain. Therapists should not assume that the woman’s pain is purely emotional and be careful to validate their client’s experience. Addressing the ways in which relationships change after a disability develops would be useful in helping women with disabilities. Focusing on social support systems might be especially useful for women who feel isolated in their disability. Group therapy might enable women with disabilities to form close relationships and address fears about changing relationships after becoming disabled.

**Practical Applications in Psychology for Clients with Disabilities**

The creations of intake forms for clients and bias questionnaires for psychologists would help both men and women with disabilities. Although there are many shared experience of men with disabilities that differ from women’s experiences with disability, it would be dangerous to generalize these common experiences and assume that all men with disabilities are the same or all women with disabilities are the same. An intake form would help therapists avoid generalizing and would enable them to know their clients personally. Although psychologists try
to avoid perpetuating stereotypes, assumptions and misconceptions about disability can be communicated subtly through language and can become internalized by psychologists.

**Intake Form**

Psychologists should know their client’s personal concerns and experiences with disability rather than making assumptions. Psychologists utilize client intake forms to gain background information on their clients. Adding questions focused on disability would enable psychologists to learn more about their client’s history and it would make therapists aware of disabilities that are not visible.

On these intake forms, a counselor could first ask if the client has some form of disability and for a history of the development of the disability. The therapist could use this form to learn about how the disability affects the client’s day to day life, relationships, and work. If the psychologist notes that the client is most concerned about how the disability affects personal relationships, the therapist could point the client towards resources for people with disabilities who desire relationships. Finally, a therapist should ask the client how the disability intersects with other identities such as sexual orientation or race.

**Psychologist Bias Questionnaire**

As psychologists work with clients with disabilities, they should investigate their own biases and assumptions about people with disabilities. First, psychologists should check their orientation towards common assumptions of disability, asking themselves if they assume that people with disabilities are vulnerable, weak, helpless, dependent, asexual, or incapable. Counselors should ask if they feel comfortable working with clients with disabilities. If they do not, they should ask themselves what they could do to feel more competent working with clients with disabilities.
The therapist’s awareness of the language they use in discussing disability should be assessed in order to determine if they are aware of the strong impact of language. As most individuals would not explicitly voice biases towards people with disabilities, it is important to note that these biases can be conveyed through small details in language. Minute differences in language can perpetuate stereotypes about disability. For example, saying “an individual who uses a wheelchair” instead of “wheelchair bound” can help psychologists avoid perpetuating stereotypes of weakness and dependence (Hadley & Brodwin, 1988). In person first language, the individual a disability rather than being defined solely by a disability. Special attention to language can help counselors acknowledge the multifaceted identities of their clients with disabilities.

**Limitations and Future Research**

There are many limitations to studying disability and gender. For example, most studies that focus on the gender of people with disabilities focuses on gender as a binary of male and female. In this study, I only addressed gender differences disability between men and women. Research on the impact of disability for people who do not identify as male or female is rare but important as individuals with multiple minority statuses have unique experiences of disability. Psychological research has just started to explore the added confounds of lesbians, homosexuals, and bisexuals with disabilities but more research is necessary for people with physical disabilities who are transgender (Fredriksen-Goldsen, & Barkan, 2012).

In addition, disability is often seen as a homogeneous category and individual differences in disabilities are not recognized. Many studies group together a wide variety of disabilities when people with these disabilities might have vastly different experiences (Foley-Nicpon & Lee, 2012). While people with disabilities share common experiences of stigmatization, a broad
definition of disability groups all people with disabilities together despite differences in severity, time of onset, and visibility of the disability which may profoundly impact the individual’s experience with disability. For example, a man who was born with a disability might not have the same conflict with masculinity as a man who was a sports star who was injured later in life. It is important for psychologists to understand the common issues that men and women with disabilities face but also recognize that each individual has their own background which may be in conflict with the expected experiences of people with disabilities.

**Conclusions**

The topic of gender and disability within psychology is small but growing. There needs to be more research into the complexity of the intersection between disability, gender, and other identities. There is also a lack of research on individuals who are transgender and genderqueer as research on the intersection between disability and gender assumes a gender binary. More research should be conducted on psychologist’s biases and the effectiveness of training programs for psychologists. Psychologists could draw from multiple disciplines in creating their therapies.

If psychologists ignore the effects of gender on their clients’ experiences of disability, they risk perpetuating stereotypes about disability and isolating their clients. Psychologists must be aware of societal assumptions of disability such as the misconceptions that people with disabilities are helpless, weak, and asexual. A bias questionnaire for psychologists would be useful in exposing psychologists to their own misconceptions about disability.

Men and women experience disability differently due to gender socialization, which may lead psychologists to address differing aspects of daily life depending on the client’s identities. For example, psychologists might focus on how a woman’s relationships have changed after she became disabled and emphasize social support in treatment. In treating men with disabilities, a
psychologist might address the ways in which their clients feel strained between expectations of masculinity and stereotypes against disability. However, the psychologists must also be careful not to generalize and assume that all men, all women, or all people with disability are the same. An intake form that addresses the individual client’s relationship with their disability would be useful in determining the individual’s unique intersecting identities.
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