

# Listening to Clients with Invisible Disabilities

You may have heard the proverb, “Seeing is believing.” This proverb limits the legitimate to what we can see, as opposed to what we hear. Even careful listening is a limited source of information. If we allowed this proverb to guide our behaviour, we might listen to a client describe a burn injury but we would not be convinced until we actually saw the scars. We might be immediately suspicious of clients who complained of pain without scars, especially in controversial conditions like fibromyalgia or chronic fatigue syndrome.

By contrast you may have also heard the proverb, “Believing is seeing.” This proverb suggests that what we can see is curtailed by prior beliefs. Johann Wolfgang von Goethe puts it nicely this way: “We see what we look for. We look for what we know.” If we followed this proverb in our daily practice, we might ask questions about tender points in clients presenting with multiple pain complaints or we might immediately switch our inquiry to mood problems or money motives – depending on prior beliefs about conditions like fibromyalgia.

Our clients with invisible disabilities are likely to be affected by our adherence, whether deliberate or not, to either proverb. It’s not just that they may have scars that they hide under clothes: they may have no physical evidence of disability at all. They may have no “organic findings.” Their condition may not have been ‘seen’ by imaging studies. In fact, if “believing is seeing,” the imaging studies may not have been ‘looking’ in the right places.

Meanwhile, we may begin to feel a festering irritation as we interview such clients. What’s the problem here? These clients *look* fine. They don’t have the obvious injuries or diseases of our other clients. In fact, we may find their disability presentation quite disproportionate to the onset of their problem. We may begin to

consider psychological explanations or even symptom exaggeration or malingering. Sometimes we fail to listen miserably. Werner and Malterud (2003) offer accounts of women with medically unexplained conditions who are ignored or even disparaged by their health care providers. These women encountered skepticism, misunderstanding, rejection and blame.

Our suspicion has consequences for clients with invisible disabilities. They may become angry and discouraged because they perceive that we misunderstand them, distrust them, and even dismiss them. They doubt themselves (“It’s all in my head”). In such circumstances, clients perceive that their integrity is being questioned. In some cases, their focus on rehabilitation may shift to defending their integrity. Ironically, they may exaggerate their disability to prove their point, and thus only reinforce suspicions about their disability.

We, as rehabilitation providers, will want to listen to clients who have invisible disabilities with the same respect and discernment as any other client. Despite our best intentions to do so, however, we are prone to error in our judgments about them. For example, in clients whose invisible disabilities are related to pain, HILL & CRAIG (2002) report success rates of 18 - 63% in our ability to accurately differentiate genuine, faked or suppressed facial expressions of pain. Craig, HILL & McMURTRY (1999) issue no less than 20 cautions concerning our judgments of deception or malingered pain. Regarding deception more broadly, there is no “Pinnochio’s nose.” It turns out that we often harbour false beliefs regarding what behaviours indicate faking or lying, such

What I have learned is that we do not have a health care system so much as we have a self care system.

as shifting behaviour, looking away, self-touches, nervous behaviour – all erroneous markers (VRIJ, 2000). If “believing is seeing” we are in danger of blindness to our clients’ true condition, especially when we are suspicious.

The situation in which we meet with clients will likely make a difference to how we perceive their disability. For example, the Diagnostic & Statistical Manual, Fourth Edition (DSM-IV) suggests that the index of suspicion for malingering should be raised in a medicolegal situation. However, in the case of malingered pain, CRAIG (1992) suggests that even if we adopt suspicion of high rates of deception, our ability to detect faked or suppressed pain displays does not improve, although we may be more inclined to attribute less severe pain. Furthermore, when we are more suspicious, we may become less effective in identifying clients who are reluctant to acknowledge their symptoms (POOLE & CRAIG, 1992).

I recommend particular attention to the influence of work settings and referral sources on our impressions of clients with invisible disabilities. There may be a culture of belief or a “group think” (JANIS & MANN, 1977) regarding invisible disabilities at your workplace that is exerting a subtle (or blatant) influence on the way you regard clients with invisible disabilities. For example, in an insurance environment you may be encouraged to take a dim view of clients with non-specific, soft tissue injuries. You may be given research articles that support this point of view. The office banter may tend to stereotype such clients as suspicious, manipulative and pathetic. On the other hand, in a plaintiff or treatment environment you may be encouraged to adopt a strong, sympathetic view of such clients. Noncompliance may have unpleasant consequences, such as the withdrawal of a lucrative referral source.

It is likely that past experiences with clients who have invisible disabilities influence your perception of them. For example, such clients may have disappointed or even duped you or a trusted colleague in the past. You may find yourself immediately withdrawing from full engagement, a protective strategy according to another proverb – ‘Once burnt, twice shy.’ On the other hand, such clients may have gained your admiration in the past so that you are now inclined to overlook dissonant information about them. Furthermore, our clients may trigger remote positive or negative memories that influence our reaction to them (NB, FREUD’S NOTION OF COUNTERTRANSFERENCE).

We intend to listen to all of our clients with both respect and discernment. However, I suggest that clients with invisible disabilities require special efforts in this regard. A good place to start is to examine any quick judgments about such clients, whether favourable or not. Another revealing exercise is to assess the typical attitude of your workplace colleagues, both staff and management,

regarding clients with invisible disabilities. You may wish to deliberately search for scientific findings that are contrary to any prevailing view. You may ask a discerning colleague to watch for biases toward clients with invisible disabilities in your work behaviour. You may also monitor variation in your attitude toward these clients across workplace settings. However, attitudes that are located at the rim of your awareness may require counselling – a revealing and enriching process with benefits for both your clients and you.

The cost of invisible disabilities in lost productivity is high. In recent years the “working wounded” – those who remain at work despite disability have received increasing attention. There is now preliminary evidence that such clients may cost employers more in decreased productivity while at work (“presenteeism”) than the cost of absenteeism. For example, Stewart and colleagues (2003) found that employees with depression, an invisible disability, cost their employers \$44 billion per year in lost productivity time. Of this \$44 billion, 81% was attributable to reduced productivity time (presenteeism), not work absence (absenteeism).

Clients with invisible disabilities, especially those who remain in the workforce as the “working wounded,” need our help now more than ever. Listening to them with respect and discernment has never been more important. But we may need a hearing test – regularly.

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