Psychosocial Adaptation to Disability and Psychosocial Considerations
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Psychosocial impact is the complex integration of verbal, cognitive, and behavioral interactions between a person with a disability, his or her environment, and the significant others in that environment. The impact of psychosocial considerations on the adjustment process of injured or other disabled individuals must be a primary concern to the rehabilitation professional. Attitudes, personal identity, motivation, and lifestyle are among the many factors that influence the psychosocial impact of disability.

Introduction

Until recently, psychological and sociological problems associated with disability were considered separately from the disability itself. Today, there is a greater tendency to consider these topics as an integral part of the disability.

Sociologically, the problem of attitudes toward persons with disabilities remains a bothersome issue. Efforts toward educating individuals in the society at large concerning the abilities and potential of persons with disabilities have made greater acceptance possible. Prejudicial attitudes may never be completely eliminated, however, since indications are that persons with such attitudes tend to generalize them to all groups perceived to be different. Great strides have been made toward the establishment of legal mandates to protect the rights of the disabled, alleviate employment discrimination, and minimize structural barriers impeding physical access in society.

Psychosocial Considerations

Disabled individuals can respond to their condition either positively through coping strategies or through behaviors that have a negative effect on their adjustment. However, the psychological impact of disability is determined not only by the emotions of the disabled person, but also by many external forces. Internal psychological states such as conflict and anxiety may be affected by external events. A client’s personality, needs, and level of motivation also
have an impact on the final outcome of the rehabilitation process.

In rehabilitation efforts, psychosocial considerations are often of greater complexity than medical considerations. The process of medical stabilization begins in a controlled environment with a great deal of structure. The injured or acutely ill person is usually treated by a team of professionals who have little opportunity to consider all the personality characteristics of their patients. After medical stabilization, on the other hand, the continuation of the rehabilitation process relies heavily on each client's motivations, feelings, and interactions with the environment.

The adjustment process is an individualized process. Outcome is dictated by how the handicapped individuals view themselves and how they are viewed by others.

The client's identity is formed by the roles he or she assumes based on meaningful relationships and/or activities. Some of these roles are assigned high priorities by the individual and can be considered primary roles, while others may not have as much importance. For example, if a production worker who operates a work station alone becomes facially disfigured, the disfigurement may or may not adversely affect her work role. The adverse effects would at least not be work-related. On the other hand, she may consider her roles as mother and spouse to be of primary importance and have evidence that her facial disfigurement has a profound negative effect on these roles. She may then focus on that loss of role identity, which in turn will effect her non-primary work role. The extent to which one's primary roles are impacted may indeed determine the severity of disability as perceived by the client.

A corollary of the above example may be a male whose father-spouse role is unaffected by the disfigurement. His primary role may be that of worker. If such a role is socially assigned, however, the client may claim many unjustifiable reasons for no longer meeting the demands of that role assignment. For example, a 48-year-old male who has always been a hard worker because of the socially expected role of “provider" may find through disability a socially acceptable reason for no longer serving in that role. This is especially probable with clients who, prior to injury, were not well rewarded for working
and thus lack the motivation to continue their efforts. Thus, the disability may provide a socially and personally acceptable reason to terminate the work role although such action is not medically or functionally justifiable.

**Conflict**

Conflict may be defined as tension due to difficulty in choosing between two or more goals. The tension usually derives from the necessity to modify one goal in order to achieve another. Three types of conflict have been identified in the field of psychology: approach-approach conflict, approach-avoidance conflict, and avoidance-avoidance conflict.

**Approach-Approach Conflict**

Approach-approach conflict occurs when tension results from the necessity of choosing only one of several attractive goals. Having to choose only one of several positive options can create intense conflict. The conflict is not based on whether the outcome will or will not be positive, but on the necessity of eliminating some positive options. In rehabilitation, one characteristic example of such conflict is the decision to return to work or accept financial benefits for disability.

**Approach-Avoidance Conflict**

Approach-avoidance conflict occurs when tension results from the desire to choose a positive goal, which will have some negative consequences. The client may wish to return to work but know that the disability-related pain will then increase, or the client may believe that return to work will cause the termination of secondary gains such as the attention and financial support he or she has been receiving.

**Avoidance-Avoidance Conflict**

Avoidance-avoidance conflict occurs when tension results from the necessity of choosing between goals which each have negative consequences. Such a conflict may be apparent in one with a severe disability whose goal has been total independence. The person may
find realistically that such a goal is not achievable because of maintenance cost, lack of condition stability, and/or unachievable necessary daily living skills. Conflict results from having to choose between living in an institutional setting with attendants or living at home and being dependent on other family members.

**Anxiety and Stress**

In addition to conflict, two other internal psychological states, anxiety and stress, become apparent in the adjustment process. Anxiety results from feelings of fear or apprehension that sometimes occur in the absence of any real danger to one's physical well-being. Such feelings may concern one's emotional well-being, as in the case of perceived threats to self-esteem or fear of abandonment. In the early stages of the adjustment process, clients may feel anxiety about social contact. In the acute phase of the rehabilitation process, disabled individuals are limited in their social contacts to medical professionals and family members. At some point during rehabilitation, they must decide whether to broaden their social contacts.

The movement toward seeking acceptance by others may create anxiety because of the implied risk of rejection. Pre-disability personality traits may determine the extent to which social contacts are initiated, or whether they are initiated at all. Generally speaking, the determining factor appears to be how clients feel about themselves aside from the condition of disability.

Stress or stressful states may have a positive and/or a negative component. From a positive standpoint, stress can provide motivation and appropriate action responses. Negative stress is manifested by a state of tension accompanied by feelings of frustration, hostility, and/or aggression. There is often an inner conflict caused by opposing wishes or external barriers to goal fulfillment. Sources of debilitating stress may be seen in chronic conditions, which do not stabilize, as commonly seen in cases involving organ transplants, skin grafts, joint diseases, and seizure disorders. In stabilized conditions sources of debilitating stress may be social, vocational, or educational. Barriers to mobility may be another cause of disability-related stress. Stress also commonly occurs during the decision
making or commitment making process.

There are two primary reactions to states of anxiety and negative stress. One is an aggressive, behavioral, or verbal attack on the perceived source of the anxiety or stress. In cases where the source of stress is not available for attack, such aggressive behavior is usually directed toward other persons or objects and may also be directed reflexively at the self. The second primary reaction to states of anxiety and negative stress is a passive response, usually taking such forms as daydreaming, disinterest, and apathy.

**Positive Response Strategies**

Various response strategies have been delineated in the rehabilitation literature. They may be categorized as either unconscious or conscious strategies. The unconscious strategies are the ego defense mechanisms described in the psychological literature. While individuals are not conscious of these strategies, they are believed to underlie much behavior. These strategies are not effective coping strategies, since they are unconscious and their purpose is to protect the ego through distortion of reality.

The conscious coping strategies, on the other hand, can enhance the adjustment process. These widely accepted strategies as discussed by Wright (1960) are as follows:

**Enlarging the Scope of Values**

In the acculturation process, the individual learns to value certain assets. Many such values are formed on the basis of one's perception of normality and ability. This strategy emphasizes that other values and beliefs can be developed, transcending the perceived or real limits of disability.

**Containment of the Effects of Disability**

By learning new skills, the client can lessen the negative effects of disability. Early in the adjustment process, clients tend to generalize the effects of their disability. A client with a dysfunctional upper extremity may generalize the effects of that dysfunction to the entire
body, ultimately feeling that he or she is useless. As the client re-experiences the usefulness of other extremities and abilities, the dysfunction is rationally contained within the appropriate area.

**Acceptance**

This strategy can have negative or positive outcomes. Acceptance of oneself as a disabled person with the limits imposed by one's previous attitudes limits possibilities. Acceptance of the true limits and inconveniences brought on by the disability enhances positive and creative adjustment processes.

**Subordinating the Physique**

This strategy may involve the shifting of emphasis from physical appearance and abilities to a greater appreciation of self-enhancing personality traits and intellectual skills. This is particularly difficult for those who have used their appearance as their primary asset in achieving social contacts.

**Counteracting Spread**

This essentially involves a focusing process. The notion of lack of functioning in a body system should not spread to unaffected body systems. This is an alternative strategy to that of containment of the effects of disability.

**Comparative versus Asset Values**

Appropriate and positive coping must begin with a realistic evaluation of residual assets. The term coping strategies, denotes a dynamic forward-looking process. Comparison of oneself with others or even with the pre-disability self is often a useless exercise.

**Negative Response Strategies**

Working against response strategies that facilitate coping, such as those outlined above, there are certain behaviors or attitudes that should alert the rehabilitation professional that the client may be giving in or succumbing to the negative effects of disability. While
negative behaviors and attitudes, if maintained over time, can result in poor adjustment, they may have positive, motivational effects in the initial phase of the adjustment process. As described by Roessler and Bolton (1978), negative response strategies are as follows:

"As If" Behaviors and Attitudes

The client typically devotes a great deal of time and effort to thinking and behaving "as if" the condition did not exist. Although not as psychologically serious as denial, "as if" behaviors can be quite bothersome to rehabilitation personnel attempting to assist the client displaying them. Usually, a relatively minor condition is involved such as modified or restricted hearing or sight. "As if" behaviors may have particularly serious implications with conditions not necessarily apparent to others, such as epilepsy.

Idolizing Normal Standards

Most disabled persons in rehabilitation settings have not been disabled all their lives. They therefore tend to have attitudes concerning disability, which were formed before they became disabled. Their attitude toward themselves as disabled can develop as a comparative value, making it difficult to appropriately assess their current state. It is not unusual, for example, for them to cling to the hope that a cure may be found which will one day render them non-disabled. While such desires are acceptable, they may also create a state of stagnation in the adjustment process. Clients should be encouraged to continue the adjustment process, not at the expense of their "hope for wholeness" or just in case they are not cured, but so that their lives reach maximum productivity and completeness until such time as their "hope" becomes reality.

Compensation

Compensation behaviors usually occur as the result of clients viewing themselves as less competent than prior to disability. A client with this type of attitude directs all efforts at compensating for a perceived deficit, which is a negative motivation. Such behaviors are inappropriate in that they tend to restrict the client's life to narrow limits. The danger in such cases is that the client may be driven to
specific successes without an associated emotionally healthy adjustment.

**Group Identification**

This attitude usually indicates a strong basic desire to be non-disabled. It may lead to attempts to avoid conditions which remind the client of his or her identity as a disabled person. Typically, such clients become overly critical of the behaviors and mannerisms of other disabled persons and wish to have no contact with them. They strive to conceal their own disability and think other persons with a disability should act similarly. A sight-restricted client, for example, may refuse to utilize such aids as dogs or canes because of the identifying effects.

**Maintaining Ambiguity**

These behaviors and attitudes may be particularly troublesome to the disabled person and the rehabilitation professional. There is an attempt not to become involved in clarifying events. Perhaps the most common manifestation of such behaviors is in the case of a client who repeatedly verbalizes a desire to return to work, despite the fact that disability or circumstance makes such a step inappropriate.

**Personality**

Roessler and Bolton (1978) offer a useful and extensive review of the available research on the relationship of disability to psychopathology, self-concept, and normal personality traits. General conclusions include the following:

1. Specific disability groups cannot be identified as having an identifiable personality type profile
2. A simple relationship does not exist between severity of disability and degree of psychological impairment
3. There is a wide range of reactions to disability by individuals within the disability groupings.

Clearly then, one cannot conclude that a given individual will react to a specific disability in any one predictable way. Neither can a
particular personality profile be used to describe all or even most persons within a disability grouping. Self-concept and/or self-esteem should be considered an important variable. General conclusions (Roessler and Bolton, 1978) are that lower self-esteem is reported more often among disabled persons than non-disabled persons. Among the disabling conditions mentioned include tuberculosis, severe disabilities among adolescents, visually handicapped adolescents, educable mental retardation, and alcoholism.

**Needs and Motivation**

Behavior tends to be based on unmet needs. Persons usually exhibit a conscious behavior based on a need of which they are aware. Some behaviors, however, are responses to needs of which one is not aware. Such needs are referred to as unconscious motivations of behavior. Often, such behavior is of a kind that works against persons without their understanding why they continue such behavior. For a behavior to continue, it must be reinforced. Need satisfaction is a potent reinforcer.

Abraham Maslow (1970) believed there was a hierarchy of needs and delineated them as follows:

1. Physiological Needs: These are the basic needs of food, clothing, and shelter; they are the basic survival needs.
2. Safety Needs: Once basic survival needs are met, one becomes concerned with safety needs, namely security, stability, and freedom from fear.
3. Acceptance Needs: Once having satisfied the needs for security and safety, needs for love, friends, intimacy, and contact with others become apparent.
4. Esteem Needs: Having some degree of love and contact with others, one becomes more concerned with feeling important, useful, competent, and needed by others.
5. Self-Actualization Needs: These are the highest order needs. There is a shift from comparative evaluations to an internalized awareness and evaluation. Persons become more concerned with reaching their potential, personal growth, and progress.

Perhaps the most important concept in such a hierarchy of needs is
that one level must be met, at least partially, before one can be concerned about the next level. Rehabilitation professionals must be able to assess needs levels in order to determine congruency with a rehabilitation program. They have unique opportunities to observe clients at various needs levels.

Clients with severe disability, which is not yet stabilized, are likely to be attending to the basic physiological and safety needs. They are most probably in hospitals in acute care wards where needs for nourishment are met by others. Such clients may become quite concerned with their potential for meeting sexual needs, another of the physiological needs. Sexual needs, however, are complicated to assess since they also involve needs at the acceptance level of Maslow's hierarchy.

Rehabilitation programming difficulties may occur after survival has been assured but before safety has been fully established. The rehabilitation professional may try to stimulate vocational planning at the esteem level. The client, however, cannot appropriately and seriously attend to vocational planning concerns if he or she still fears mobility. It becomes clear that the professional's primary function is to assist or procure assistance for the individual to satisfactorily work through the levels of immediate concern.

As the disabled person becomes comfortable being in contact with others and experiences caring attitudes, he or she will become more concerned with feelings about the self, doing something useful, and becoming competent and needed. There follows a quite natural motivation toward return to work, since in our culture employment seems to be the most accepted way to achieve alleviation of esteem needs. Coupling the needs hierarchy concepts with principles of behavior management can work toward initiating and maintaining appropriate attitudes and behaviors.

The satisfaction of needs relates directly to positive outcomes in the rehabilitation process. Roessler and Bolton (1978) reviewed the literature relative to the variables affecting the outcome of the rehabilitation process and adjustment to disability. The younger a client is at the onset of disability or at the inception of the rehabilitation process, the greater chance there is for positive outcome. General
health, marriage, education, vocational training, job skills, and intelligence are all related factors, which may continue to a positive outcome. Among the specific circumstances, which may enhance appropriate adjustment to disability are healthy relationships within one's family, residence in an area close to employment and training opportunities and a recent history of stable employment with high earnings.

**Works Cited**