People acquire physical disabilities through aging and a multitude of mishaps, diseases, and infections. Although clinicians have offered many different explanations for the diverse psychological reactions that occur in the wake of physical disabilities, few have applied scientific tools to study these behaviors, and fewer still have presented heuristic and testable theoretical explanations. Moreover, most observers have overlooked the potentially valuable experience of acquiring a physical disability. Writers have given only scant attention to positive growth and optimal living with chronic health problems, as well as the related searches for meaning, purpose, and fulfillment.

In this chapter, we first will review the historical perspectives regarding adjustment to the onset of physical disability. We then will present a model for understanding such adjustment, along with supporting evidence. Finally, we will discuss relevant measures and intervention practices that merit use in practice and research and will propose directions for future study.

**Historical Perspectives**

In most conceptualizations of psychological adjustment following the onset of physical disability, researchers have focused primarily on the negative emotional reactions; rarely have they mentioned the potential for psychological growth. For many years, the prevailing models of adjustment were Freudian ones in which people were presumed to pass through predictable stages in reaction to severe loss (Grzesiak & Hicock, 1994). With the losses accompanying the disability, the individual was posited to sustain a severe blow, and only with the passage of time could the ego permit recognition of that loss. Thus, a person purportedly would manifest denial to defend against the anxiety precipitated by the disability and thereafter would gradually progress through depression, anger, and bargaining phases until the ego could rationally accept the permanence and severity of the disability (Mueller, 1962). Thus, optimal adjustment was conceptualized as the final acceptance of the reality of permanent disability.

In contrast to this rather fatalistic perspective, students of Kurt Lewin (1939) observed great variation in reactions to physical disability. They recognized that many people manage the negative implications of the disability by shifting their values so as to experience increased personal worth (Barker, Wright, Meyerson, & Gonick, 1953; Dembo, Leviton, & Wright, 1956; Meyerson, 1948). Additionally, these research-
ers demonstrated how physical settings and societal attitudes impede personal growth and adjustment following the onset of a disability. These views facilitated the recognition of the potential for optimal positive adjustment following physical disability; moreover, they influenced a generation of psychologists, counselors, physicians, and policy makers. Finally, these views shed light on the limitations imposed by the physical environment and the ways in which the environment can define a person as “handicapped” (Shontz & Wright, 1980).

Learning principles also have been applied to identify environmental contingencies that reinforce and shape “disabled” behaviors and produce impairment that is beyond what can be directly attributable to a physical condition (Fordyce, 1976). These applications have been expanded to take into account specific beliefs people develop in interactions with the environment, and the way people find meaning in their daily experiences (Fordyce, 1988). In other models steeped in a learning tradition, the theorists consider the interactions of both the characteristics of the disability and personal coping behaviors in influencing adjustment (Thompson, Gil, Burbach, Keith, & Kinney, 1993; Wallander & Varni, 1989).

In much of the available empirical research, the approaches have been largely descriptive, detached from overarching theoretical models, and centered upon the measurement of distress and other negative emotional reactions (Livneh & Antonak, 1997). Unfortunately, this work does not increase our understanding of how people can experience positive growth and meaning following disability. Indeed, psychological models in which persons with a disability are portrayed as recipients of care or victims of misfortune preoccupied with matters of health cannot inform us about positive growth following disability (Scheier, Weintraub, & Carver, 1986), and post-traumatic growth (Tedeschi, Park, & Calhoun, 1998). These concepts signify the possible occurrence of positive growth in response to a stressful incident, but at times the labels and definitions of these constructs seem condescending, suggesting that observed behaviors may not be “real” or reflective of genuine change.

As early as 1956, Dembo and her colleagues pointed out that for some persons, disability is neither the “core” of their self-worth nor the center of their daily activities. In fact, many believe that their disabilities have helped them to find meaning or to take a more adaptive perspective of life (Wright, 1983). These individuals reported (a) appreciating personal worth regardless of appearance or ability; (b) valuing time spent in family activities; and (c) becoming more spiritual, thoughtful, or understanding (Taylor, 1983; Wright, 1983). According to Wright (1983), persons who have developed greater acceptance of disability will demonstrate a sense of meaning in their circumstances, value their selfhood, and maintain positive beliefs about themselves. Such changes may be construed as both process and outcome and may be reflected in a heightened sense of priorities, a greater appreciation of the preciousness of life, and an inner strength and meaning that permeates daily decisions and activities (Tedeschi et al., 1998).

Families, too, may experience positive changes in the wake of disability. Olkin (1999) observes that acquired disability can force family members to directly confront issues of trust, mortality, and values, which in turn compel them to develop deeper commitments and restructure the meaning of marriage or kinship. Some family members report a greater sense of closeness, a greater emphasis on family and personal relationships, and positive changes in shared family values (Crewe, 1993).

Positive growth can be reflected in a greater sense of well-being and satisfaction with life and also may be associated with fewer psychological problems such as depression, anxiety, social isolation, and loneliness. Presumably, positive growth should be associated with a decreased
risk and infrequent occurrence of secondary complications (e.g., pressure sores, urinary tract infections, respiratory problems), that may be prevented in part by observing regimens for personal care, avoidance of possible damaging stimuli, and other health-promoting behaviors. We believe that persons who attain a greater degree of positive growth following disability would be more likely to engage in behaviors conducive to general well-being and optimal physical health.

An Integrative and Dynamic Model

To appreciate the potential for positive growth and optimal adjustment following physical disability, it is necessary to review several basic tenets in rehabilitation psychology. First, disability does not occur in a vacuum: It is defined in part by the immediate environment and the historical and societal context in which it occurs. According to the Lewinian equation, \( B = f(P,E) \), observed behavior following disability (e.g., passivity, aggression, well-being, search for meaning) is a function of the person and the environment (Wright, 1983). Stage models, learning principles, and field-theory perspectives also acknowledge that dynamic processes occur in ongoing interactions between the person and the environment. Through transactional models in which the focus is on the interplay between the person and the environment, we have increased our understanding of stress and coping processes (Lazarus & Folkman, 1984). Unfortunately, researchers and clinicians often have failed to attend to within-person dynamic growth that may occur with aging (Trieschmann, 1987), the cognitive adaptations to a physical condition over time (Rape, Bush, & Slavin, 1992), as well as the interpersonal world changes that follow a disability (Frank et al., 1998). This dynamic, developmental aspect is a powerful, albeit long neglected element of the adjustment process following disability.

Second, in stage theories and Lewinian concepts it is assumed that the unique characteristics of the individual are involved in the adjustment process. Whereas in Lewinian psychology, individual characteristics are conceptualized as “the person” in the previous equation, competing stage models identify an individual difference construct (i.e., the “ego”) as having a bearing on adjustment. In contemporary parlance, these constructs represent the domain of enduring personality characteristics that can predispose an individual toward certain behaviors.

As depicted in Figure 50.1, we conceptualize adjustment following disability in several broad-based domains, each of which has considerable influence on two areas of adjustment. The primary components involve individual characteristics and the immediate social and interpersonal environment (see left side of Figure 50.1). These influence the phenomenological and appraisal processes that constitute elements of positive growth and, in turn, predict psychological and physical health outcomes (see far right side of Figure 50.1). These components are framed within the developmental continuum that flows left to right and is shown at the bottom of the figure. The dynamic continuum encompasses changes in any of the aforementioned five areas as people age, as technologies advance, as relationships shift, and as health and public policies evolve. This continuum reflects the ongoing process of growth, adaptation, and development in the person and the environment, and the subsequent alterations in interactions between these entities. Thus, in our model, we adopt a collectivistic approach in which behavior results from the combined interactions of individual, situational, and environmental factors that function in an integrated and fluid manner.

Enduring Characteristics and Individual Differences

Many variables are subsumed within this aspect of the model. Enduring characteristics are defined as demographic characteristics, disability-related characteristics (e.g., level of injury and pain), predisability behavioral patterns, and personality characteristics.

Demographic Characteristics

Few researchers have taken a priori theoretical perspectives in examining racial, gender, age, or socioeconomic status (SES) differences as they relate to adjustment following disability (Elliott & Uswatte, 2000; Fine & Asch, 1988b). Most demographic characteristics are included in clinical studies for descriptive purposes only, and their relation usually is examined within the context of maladjustment. Of those studies that included analyses of race, gender, age, and SES, these variables appeared to account for a very
small portion of variance in adjustment following disability. It should be noted that the socially defined constructs such as race, gender, ethnicity, SES, and age share considerable overlap with the social and environment component of our model.

**Disability-Related Characteristics**

Aspects of any specific disability (e.g., level of spinal cord injury) do not reliably predict subsequent adjustment, although some differences may be observed between groups of people with different types of disabilities. Changes in the physical condition itself can influence routine activities, available resources, and ongoing behavioral patterns, thereby affecting adjustment. For example, research has demonstrated that the presence of chronic, unresolved pain can be distressing to persons with physical disability, and it can compromise their abilities to come to terms with their condition and find meaning and purpose in life (Li & Moore, 1998; Summers, Rapoff, Varghese, Porter, & Palmer, 1991).

**Predisability Behavioral Patterns**

People who engage in health-compromising behaviors and have problems in interpersonal adjustment prior to their disabilities often have difficulty coming to terms with disability. Previous researchers have demonstrated a link between these characteristics and behavior, but a theoretical model has not been developed to facilitate understanding of this relationship within the context of disability. Some persons have complicated histories of alcohol and substance abuse that may have contributed to the injury (Bombardier, 2000). These persons are at risk for developing secondary complications (e.g., urinary tract infections, pressure sores) that might be prevented in part by behavioral self-care regimens (Hawkins & Heinemann, 1998; Kurylo, Elliott, & Crawford, 2000).

**Personality Characteristics**

Many psychological constructs have been related to adjustment following disability. For example, persons who have an internal locus of control often report less distress than those with more external expectancies (Frank et al., 1987). Persons with a disability who have effective social-problem-solving skills and who have positive orientations toward solving problems are more assertive, more psychosocially mobile, more accepting of their disability, and less depressed than their counterparts who lack these skills (Elliott, 1999; Elliott, Godshall, Herrick, Witty, & Spruell, 1991). There also is evidence that people with a physical disability who de-
velop preventable medical complications secondary to the disability lack effective problem-solving skills (Herrick, Elliott, & Crow, 1994).

Snyder’s (1989) conceptualization of hope, which incorporates one’s perceived ability to identify and pursue personally meaningful goals under times of duress, also is a useful construct in understanding positive growth after acquired disability (see Snyder, Rand, & Sigmon, this volume). Persons who are hopeful selectively attend to certain aspects of their situation following the onset of disability (Elliott, Witty, Herrick, & Hoffman, 1991). Moreover, persons who have higher levels of hope seem to have a greater sense of control over their symptoms and report a greater sense of personal, positive growth in reaction to their condition (Tennen & Affleck, 1999). Higher levels of hope and goal-directed energy are associated with less distress, greater use of more confident and sociable coping styles, and higher self-reported functional abilities (Elliott & Kurylo, 2000; Elliott, Witty, et al., 1991; Jackson, Taylor, Palmatier, Elliott, & Elliott, 1998; Laird, Snyder, & Green, 2001). Generally, people who have greater tendencies to utilize denial and who have greater psychological defensiveness are less distressed and less angry and have fewer handicaps throughout the first year of acquired disability (Elliott & Richards, 1999). Snyder (1989; Snyder, Rand, & Sigmon, this volume) has repeatedly emphasized that hope is goal-oriented and goal-based. Goal orientation is also significant in contemporary neo-Freudian conceptualizations of the self and personal adjustment. A greater goal orientation is associated with less depression, greater acceptance of disability, and increased life satisfaction 1 year later among persons with recent-onset physical disability. Goal orientation also is associated with less perceived social stigma and increased mobility among these persons (Elliott, Uswatte, Lewis, & Palmatier, 2000). Among persons with chronic disabilities, those who have many rather than few goals evidence more optimal adjustment (Kemp & Vash, 1971).

Other personality traits are predictive of adjustment as well. Krause and Rohe (1998) found that elements of neuroticism and extraversion were associated with life satisfaction among community-residing persons with spinal cord injuries. Specifically, a greater proclivity for negative emotions and decreased tendency for positive emotions were predictive of less life satisfaction. Similarly, Rivera and Elliott (2000) found that lower neuroticism and higher agreeableness (measured by the NEO; Costa & McRae, 1991) were predictive of greater acceptance of disability among persons with a spinal cord injury after controlling for level of injury, completeness of injury, depression, and demographic variables. Thus, the personality traits that are stable and unlikely to change over time appear to be significant correlates of depression and acceptance of disability in persons with an acquired spinal cord injury.

Social and Interpersonal Environment

Elements of interest within the interpersonal and social environment portion of our model include social support, environmental barriers, and social stereotypes. Social support has been associated with well-being among persons with acquired disabilities (Rintala, Young, Hart, Clearman, & Fuhrer, 1992). The fluid nature of social support may reflect the various types of assistance (e.g., informational, emotional) required to complement specific coping efforts (McColl, Lei, & Skinner, 1995). Family members may shift in their own adjustments and abilities to cope with the caregiving demands, thereby affecting the care recipients’ abilities to cope (Chaney, Mullins, Frank, & Peterson, 1997; Frank et al., 1998). There also is evidence that elements of social support can have positive and negative effects on other aspects of adjustment. For example, assertive persons may be able to marshal available social support in certain situations; however, this direct style also may alienate others in the social support system (Elliott, Herrick, et al., 1991). Similarly, goal-directed persons who voice their aspirations and do not assume a passive role in rehabilitation might encounter negative and resistant attitudes from professional staff (Elliott & Kurylo, 2000).

Marital satisfaction following disability is associated with greater satisfaction in leisure activities (Urey & Henggeler, 1987), and satisfaction with recreational activities is a major component of overall life satisfaction following disability (Kinney & Coyle, 1992; Krause & Crewe, 1987). But significant others also can have a negative impact in the way they may reinforce disabled behaviors, undermine self-care efforts, restrict activity, and compromise the health of a person with disability (Turk, Kerns, & Rosenberg, 1992). In some situations, family members have to make a conscious choice between the personal goals of the person...
with a disability and contradictory goals espoused by health care professionals (Elliott & Kurylo, 2000). In other cases, family members may be unable to adjust to the changes imposed by the disability and display more distress than the person with the condition (Elliott & Shewchuk, in press).

We also are learning that family members in caregiving roles can have an impact on the psychological and physical adjustments of persons with disabilities. In a recent study, caregiver tendencies to solve problems carelessly and impulsively were significantly predictive of lower acceptance of disability among patients who were leaving a rehabilitation hospital (Elliott, Shewchuk, & Richards, 1999). When a group of these patients were evaluated a year later for the occurrence of pressure sores, caregiver impulsive and careless styles assessed 1 year earlier correctly classified 87.88% of those persons with and without a sore. It is conceivable that the persons with disabilities were aware of their caregivers’ problem-solving styles and recognized that their caregivers could care less about working to help them in adhering to self-care regimens.

The social environment can yield considerable stress because persons with disabilities are impeded from being integrated and mobile in society at large. Factors ranging from architectural barriers to negative social stereotypes contribute to this stress. Perceived independence, personal transportation, and personal living arrangements are strong predictors of good self-concepts among persons with a physical disability who reside in a community (Green, Pratt, & Grigsby, 1984). Some persons with disabilities may become very uncomfortable in anticipation of potentially embarrassing situations associated with interacting and resuming social roles (Dunn, 1977). To compound the problems, these concerns may be internalized as social stigmas. On this point, persons with higher levels of perceived stigma report more problems coming to terms with their disabilities (Li & Moore, 1998; Ryбарczyk, Nyenhuis, Nicholas, Cash, & Kaiser, 1995).

Phenomenological and Appraisal Processes

We must understand the unique perspective of the person with disability. In contemporary perspectives of adjustment, an emphasis is placed on the importance of appraisals in understanding individual experiences. For example, there is a focus on the primary appraisal of events as the mediators of stress effects in transactional models of stress and coping. In concert with these views, rather than the disability itself, the research focus has shifted to the person’s perceptions of disability and interference with personal goals and desired activities as the source of stress (Williamson, 1998; see also Williamson, this volume). Thus, we focus on the perception and appraisal of stress in our model and do not make assumptions about the discrete nature of stressful incidents among people with disabilities.

The appraisal component, then, is the centerpiece of our model because its processes have considerable influence on subsequent adjustment. We believe that elements of positive growth are first evident in how people evaluate and interpret their situation and circumstances. Following disabilities, adaptive people often look inward to exercise control over internal states rather than trying to exert behavioral control over external events, some of which they realistically cannot affect (Heckenhausen & Schulz, 1995). Individuals then actively process aspects of their situations to find positive meanings and side benefits (Dunn, 1996, 2000). We can observe how people try to accept, positively reinterpret, and seek personal growth soon after the onset of disabilities (Kennedy et al., 2000). Those who are successful in realizing these aspects will have better adjustment (Thompson, 1991). Appraisal processes also may help to explain why persons with disabilities who are distressed exhibit many different coping behaviors, whereas those who are less distressed reported fewer coping efforts and a greater sense of internal locus of control (Frank et al., 1987). This also may account for the beneficial sequelae of acceptance coping and cognitive restructuring on the adjustments of persons with spinal cord injuries who are returning to their communities (Hanson, Buckelew, Hewitt, & O’Neal, 1993; Kennedy, Lowe, Grey, & Short, 1995).

Specific beliefs about the disability (e.g., “I will walk again”) and attributions of responsibility and blame are unstable over time and have been found not to be consistently related to objective and subjective measures of adjustment (Elliott & Richards, 1999; Hanson et al., 1993; Reidy & Caplan, 1994; Richards, Elliott, Shewchuk, & Fine, 1997; Schulz & Decker, 1985). People who ruminate about their perceived victimization, however, may do so at the
expense of finding meaning and direction in their circumstances. Thus, they may compromise their adjustments (Davis, Lehman, Wortman, Silver, & Thompson, 1995). Yet others may interpret information in a manner that exacerbates their problems (Smith, Peck, Milano, & Ward, 1988). Dunn (1994) observes that adaptive personality and interpersonal characteristics predispose some individuals toward more functional cognitive appraisals, and that people lacking in these personal and social resources will be more likely to exhibit difficulties in accepting their condition and their circumstances.

Dynamic and Developmental Processes

Changes in a person’s belief system, interpersonal environment, and physical health may occur over time. Advances in medical therapies and public policy can facilitate adjustment. One hundred years ago, Helen Keller gave Americans an example of functional adaptation to multiple “limitations” (blindness, deafness, and gender). Were it not for the zeitgeist, her success as a speaker and educator may not have been realized. The sociopolitical climate at the time, including the suffragist movement, supported her efforts to integrate and prosper in mainstream society. Other examples of social advocacy led to the passage of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990. More recently, attention has turned to actor Christopher Reeve, resulting in increased public awareness about—and federal and private funding for—spinal cord injury research. Today’s advocacy movement demands consideration for the relationship between individuals and their physical, social, and cultural environments.

People typically navigate developmental changes with the intention of minimizing their discomforts and activity restrictions and maintaining or improving ability levels, senses of well-being, and volitions (Williamson, 1998). Persons with physical disabilities may grow positively over time as they develop adaptive beliefs and experience shifts in their values. Some of these positive aspects may take time to be realized or appreciated. All of these changes represent developmental processes that can be understood within the context of our model. Observations of such adjustments can be made with tools that are sensitive to individual trajectories of adaptation over time.

There are many different measures of specific beliefs, values, and attitudes that represent certain appraisal processes, but we advocate the use of instruments such as the Acceptance of Disability Scale (Linkowski, 1971), which was developed to assess acceptance as defined by Wright (1983). Other instruments that assess aspects of positive growth are available (e.g., the Posttraumatic Growth Scale; Tedeschi & Calhoun, 1996), but we are unaware of any previous application of these among persons with physical disability. To understand specific and phenomenological processes that underpin positive growth and subsequent adjustment, we believe sophisticated qualitative devices (e.g., Q-sorts, focus groups, structured interviews) are required.

Adjustment Following Disability

Paralleling the indices of adjustment for people in general, we posit two broad areas of optimal adjustment for persons with physical disability: psychological and physical health. These domains share considerable overlap. Traditionally, researchers have attended to negative indicators of adjustment by using measures of distress, depression, anxiety, psychosocial impairment, and divorce. Some measures of physical health also are construed in fairly negative terms (e.g., Sickness Impact Profile; Bergner, Bobbitt, Carter, & Gilson, 1981). Some outcomes—returning to work or receiving vocational rehabilitation services—are associated with reports of well-being. For those persons who have these options, these are important, discrete indicators of psychological adjustment (Szymanski, 2000). Meaningful social and leisure activities also are important indicators of adjustment that fit within this domain (Krause & Crewe, 1987).

We advocate using measures that draw on positive aspects of adjustment after acquired physical disability. In this regard, we would suggest the Satisfaction With Life Scale (Diener, Emmons, Larsen, & Griffin, 1985) and the Life Satisfaction Index (Adams, 1969), where the respondent is provided with an opportunity to consider positive growth and meaning in the face of significant personal change.

In sum, the individual, social, environmental, and phenomenological factors in our model are likely to have significant effects on psychological and physical health. Overall health, in turn, appears to contribute significantly to variation in positively valued outcomes such as self-
esteem, acceptance of disability, and life satisfaction. Greater recognition and attention to the factors in this model will aid our understanding of the potential for optimal adjustment among persons with acquired physical disabilities.

**Psychological Interventions**

With the decreasing financial support for psychosocial programs for persons with disabilities in the last decade, there has been a shift in intervention policies (Frank, 1997). The opinions, goals, and aspirations of the person with disability must be primary in developing strategic interventions (Wright, 1983). When these personal goals and aims are addressed, interventions are more likely to be effective (Glueckauf & Quittner, 1992; Webb & Glueckauf, 1994). Wright (1983) recommended that services to people with disabilities include efforts to eliminate societal barriers, increase accommodations, improve medical and psychosocial services where indicated, develop and provide assistive devices and technologies, and aid in the learning of new skills. For example, programs such as interpersonal and social-skills training and innovative interventions such as aerobic exercise training have led to an increase in abilities, sense of well-being, and acceptance of disabilities among persons with physical disabilities (Coyle & Santiago, 1995; Dunn, Van Horn, & Herman, 1981; Glueckauf & Quittner, 1992; Morgan & Leung, 1980). Cognitive-behavioral interventions designed to enhance coping effectiveness may have beneficial effects on people’s ability to positively reappraise their situations and to increase their senses of hope, with corresponding improvements in psychological adjustment (King & Kennedy, 1999). Strategies that include family members as an integral part of the rehabilitation process may be particularly effective (Moore, 1989); moreover, these approaches may be couched within cognitive-behavioral frameworks and delivered in innovative, home-based programs (e.g., Roberts et al., 1995). Formal vocational rehabilitation intervention programs that support a return to career-related activities—broadly defined to include support for independent living, assistive devices, and meaningful social activities—remain important despite the constant threat of decreasing federal and state funding.

To appreciate the unique perspectives of persons living with disabilities, it is prudent to hire staff members who have disabilities. This not only will enhance service provisions but also will model professionalism, independence, and self-sufficiency for the individuals served. Additionally, clinicians should solicit input from persons with disabilities and their families so that useful and desired services are developed (Shewchuk & Elliott, 2000). With qualitative assessment devices, we can measure participants’ goals and needs and expedite their inclusion in the evaluations of the intervention programs. Health professionals also must advocate legislation and seek new funding sources in order to create accessible and affordable community-based programs (e.g., support groups, educational interventions, recreational activities, and training for individuals with disabilities). Likewise, clinicians should strengthen their multidisciplinary collaboration so as to offer community-based services, including respite and home health care. For example, professionals can work together to develop neighborhood centers in rural, underserved areas or use technology such as telecommunication devices to deliver a variety of services and therapies to participants at home (Temkin & Jones, 1999). Other technologies and assistive devices can have immense effects on positive growth (Scherer, 2000). Virtual-reality technologies can be used to help individuals learn specific coping skills (e.g., coping with persistent pain; Hoffman, Doctor, Patterson, Carrougher, & Furness, 2000) and attain greater mobility and independence (learning driving skills; Schultheis & Rizzo, in press). These technologies will eventually prove to be cost-effective and, accordingly, should be subsidized by health insurance, state or federal funds, or a combination of sources.

As increasing numbers of Americans are affected by the need to care for an older adult relative, states are feeling the burden of financing long-term care services. Fortunately, policy makers are beginning to recognize the value of supporting family caregivers as an extension of the formal health care system. In fact, in a recent study by California’s Family Caregiver Alliance, it was found that five states (California, New Jersey, New York, Oregon, and Pennsylvania) now offer a variety of innovative and cost-effective services to support caregivers of family members with dementia (Feinberg & Pilisuk, 1999). Similar solutions may decrease the concerns that rehabilitation professionals have regarding the lack of input and choice of health
care services available to persons with disabilities. Likewise, a more consumer-oriented system of care may evolve (Kosciulek, 2000).

Future Directions

Many correlates of adjustment following disability have been identified in research to date. This work should continue so that we can identify those persons who are at risk for poor adjustment; moreover, we need to recognize the characteristics of those persons with disabilities who should experience greater satisfaction, health, and well-being over time. Nevertheless, several issues warrant our attention in future research programs pertaining to beneficial interventions, service delivery, and policy formation.

First, participants’ perspectives, opinions, beliefs, and appraisals have not been consistently taken into account in research and practice. To assess and use this rich but subjective information, more sophisticated qualitative measurements are necessary. Too often researchers and clinicians eschew this approach, opting to bind participants’ life experiences to some a priori Procrustean bed of theory and lore. To understand the cognitive mechanisms underlying optimal adjustment—and the precursors of such processes—it is imperative that we develop and use qualitative devices that are sensitive to the perceptions and beliefs through which people find meaning rather than despair following disability. We have yet to determine what kind of value shifts occur following disability, how and why these occur, and the relationship of such shifts to a sense of acceptance and well-being (Keany & Glueckauf, 1993).

Second, through more sophisticated statistical methods we now can uncover the dynamic processes of adjustment as they unfold over time. Designs that incorporate constructs from our model can be used to predict individual trajectories of adaptation. Included in this statistical armamentarium are hierarchical linear modeling, structural equation modeling, and other complex multilevel modeling techniques that trace various characteristics and measures over time, as well as intrapersonal and intra-individual change trajectories in intervention research (Drotar, 1997; Elliott & Shewchuk, in press). These elegant tools are particularly attractive for theory building and program evaluation because they can accommodate dichotomous and ordinal-level variables. Additionally, these techniques allow us to revisit old notions of adjustment that never have truly been tested (e.g., Do people experience a series of stage-like processes in reaction to the disability onset?) and refine predictive models that are essential for resource allocation (e.g., What are the psychological characteristics of those who benefit optimally from interventions? Who is at greatest risk for rehospitalizations?).

By using these new statistical procedures in tandem with qualitative devices, we also may illuminate how people cognitively process information about their disabling conditions, their lives, and their environments; likewise, we may better appreciate how such changes in perceptions relate to long-term adjustment. This information is crucial for improving our theoretical understanding of life beyond disability and for developing policies and service delivery systems to ensure that persons with disabilities may participate fully in a positive psychology in the 21st century. Everyone deserves a chance at “the good life,” and this is the spirit in which we have advocated new and better science, interventions, and environs for persons with disabilities.

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