CHAPTER 20

Hope over Acquired Disability: Lessons of a Young Woman’s Triumph

Timothy R. Elliott and Monica Kurylo

"We must accept finite disappointment, but we must never lose infinite hope.

Martin Luther King Jr. / Speech to Levy, 1977

THE ACCIDENT

On a dark night in February of 1998, two 16-year-old girls were driving down an interstate from Atlanta to visit the Auburn University campus. Stacy, who was driving, was an honors student at a private academy in the Atlanta area and had plans to pursue medical school. They were singing along to their favorite song and talking about their future lives as undergraduate nursing students. Soon after crossing the state line, they encountered an accident scene. Stacy swerved to miss the traffic on the right, clipping a car as she did so. She then swerved to the left to avoid hitting another car. Stacy did not see the semi-trailer parked off to the left in the median, and she rear-ended the trailer at approximately 60 mph.

Stacy’s sister, Jennifer, who was a student at Auburn and anticipating the girls’ visit, had not heard from her sister. After a few hours, she became worried. She called her parents, who then contacted the highway patrol. They wondered whether there had been any accidents that night on the interstate. Although they had been reported, the information available at that time was incomplete. They called back and asked again, but received the same, short reply.

Finally, Jennifer called the highway patrol and said that she was worried about her younger sister, and they gave her the license plate number and make and model of the car. She was then told that her sister indeed had been in an accident on the interstate highway.

Stacy’s mother, a national intensive care nurse, was at work at the time of the accident. She had recently lost a brother in a car accident. “We had gone through this before, and for..."
was already dead. And so I was saying, ‘Is she alive?’ and they kept saying, ‘Yeah,’ and I was saying, ‘Is she on a ventilator?’ and I was trying to get her ventilator settings and her blood gases, and they were saying, ‘Mrs. Gupta, you need to get on the road.’ And I said, ‘Well, my husband is on his way to get me, but my brother died three weeks ago, and nobody would tell us and please don’t let me drive down there and leave her already be dead.’ And they said, ‘She is alive, but I’m not sure she’s going to be alive when you get here.’”

While Stacy’s parents were being informed of the accident, Stacy’s friend—Melissa—was undergoing emergency surgery. She was ejected from the vehicle quickly and was immediately taken to the hospital. However, Melissa died of massive internal injuries during surgery. Stacy was trapped in the driver’s seat for one to two hours before they were able to secure her from the wreckage. Upon admission to the emergency room, Stacy had a Glasgow Coma Scale score of 5. She had sustained a severe closed head injury, massive facial swelling, internal injuries, and severe leg injuries. She would also require emergency surgery, but she would live.

Making Sense of Disability and Trauma

The sweeping, permanent, and sudden changes that occur in the wake of an acquired disability radically alter the way a person perceives any task or participates in any personal or social role. Theories have proposed that severe disabilities—particularly that of an adversarial onset—shatter assumptions about life (Janoff-Bulman, 1989), initiate a reevaluation of personal values (Hendin, Leventhal, & Wright, 1975; Wright, 1983), and usher in issues of bereavement that accompany catastrophic loss (Harvey & Miller, 1998). These changes can be overwhelming to most people, and a sense of optimal adjustment may seem far-fetched soon after injury. As in Stacy’s situation, the initial primary concern of attending professionals and family was focused on preserving her life.

Issues of adjustment and making sense of the accident and its consequences soon after consciousness is regained, however. In the face of facts and consequences, the individual must deal with what has transpired. Stage-like models derived loosely from Freudian notions of adjustment stipulated that people pass through rather predictable stages or phases in which the ego accommodates the injury (Gerszten & Hock, 1994; Gunthor, 1971). In these models, individuals supposedly had little choice but to passively experience a series of stage-like reactions (ranging from denial to depression to anger to bargaining) before the ego could rationally and logically accept the permanence and severity of the condition (Mueller, 1962; Nemiah, 1957). Many clinicians continue to subscribe to the healing properties of, time, the inevitability of stages and phases of adjustment, and the necessity of a fatalistic—yet rational—acceptance of the harsh reality of disability.

Empirical research has not supported the basic tenets of these previous ill-defined conceptualizations (see Frank, Elliott, Corcoran, & Wonderlich, 1987; Silver & Wortman, 1989), thereby prompting researchers to consider social-cognitive
mechanisms. There is considerable variation in the ways in which people find meaning and direction and reconstruct their values following traumatic disability (Oman, 1994). Many people maintain positive beliefs about the self and one's future, and these beliefs persist in the face of conditions threatening to the self. These beliefs are often accompanied by a sense of self-esteem, creative capacity, goal-oriented behavior, and empathy for others (Taylor, 1983; Taylor & Brown, 1988). Snyder's (1984) two-factor model of reality negotiation asserts that positive and negative behaviors operate in times of distress so that a person will maintain beliefs that distance oneself from information that has negative implications for the self-image, but will simultaneously adhere to positive, optimistic beliefs that enhance the self-image.

**Negotiating Reality with Hope**

Hope is the active ingredient in the maintenance of a positive self-image and future following the onset of a traumatic, disabling condition (Snyder, 1998). Snyder emphasized that hope entails a sense of agency, which signifies a goal-directed determination to maintain the self and one's goals in the face of negative events. This provides psychologicaldistance and preserves a sense of wellbeing in the face of the pain and the loss that accompanies disability. Hope also encompasses a sense of pathways, which is the individual's perceived ability to plan ways to achieve and realize personal goals.

In an application of this hope model, Elliott and colleagues found that both agency and pathways scores were associated with less depressive behavior and psychological impairment among persons with acquired spinal cord injuries (Elliott, Witty, Herrick, & Hoffman, 1991). A significant interaction revealed, however, that a greater sense of agency was associated with less impairment among those with recent injuries, but this relationship was attenuated among those who had been injured for some time. In contrast, a higher sense of pathways was associated with less impairment among those who had been injured for some time. Thus, there is some indication that the agency component may have protective effects soon after disability onset, whereas over time, the sense of pathways enables an individual to find meaning and resume social roles in life.

Reality negotiation processes are pronounced among persons who experience traumatic disability (Elliott et al., 1991), degenerative physical disease (Taylor, 1983), and victimization (Janoff-Bulman, 1989). Research has revealed that general tendencies to deny negative information about the self are associated with less distress, less hostility, and fewer problems associated with disability in the first year of acquired disability (Elliott & Richards, 1999). Higher hope is positively associated with more functional abilities among persons entering a rehabilitation program for visual impairments (Jackson, Taylor, Fuldner, Elliott, & Elliott, 1990). Additionally, hope has been inversely related to indices of distress among children with sickle
HOPE IN THE FAMILIAL CONTEXT

"The main thing they had to do that first night was stabilize her," Mrs. Craft reported. She was sent to surgery to have an intracranial pressure (ICP) monitor placed so that they could monitor the intracranial swelling in her brain. Surgical intervention for the significant damage to her leg, broken left femur, bilateral lung contusions, broken right rib, and facial reconstructive surgery would be performed later. In all, she would have at least ten surgeries within the first year after the accident.

Stacey stayed in the first hospital in Eastern Alabama for two weeks and then was transferred to a hospital closer to her parents’ home for the next two months. She was in a coma for nearly her entire stay at the first hospital and remained comatose for about two weeks after she was transferred. While she was comatose, her family and friends, especially her mother, frequently provided mild stimulation through physical therapy, music, and one-way conversation. Her mother described typical activities: "I put high-top timber shoes on her left right so she wouldn't experience foot drop, and we would force her to hold Boatie Bathie and stuff. At first, she would squeeze the left hand, but she wouldn't squeeze the right hand... I would make everybody address her from the right side of the bed because she was kind of pictured more toward the left. So I thought maybe if we stimulated her from the right side everything would be okay." Stacey's mother also frequently updated Stacey on her events and would encourage others to do the same, despite the fact that Stacey could not respond.

Although Stacey's mother was warned not to overwhelm Stacey with too much stimulation, she preferred to provide minimal stimulation to none at all. So she played classical music on CDs for Stacey, particularly pieces from Mozart. When friends would visit, they would play music from Stacey's favorite group, Narnia. After a few visits, her friends noticed that Stacey would mouthing the words to her favorite Narnia songs as they played, despite the fact that she was comatose.

The Crafts also relied on their faith during Stacey's recovery. While the Crafts prayed with family and friends who visited, frequent prayer sessions for Stacey's surgery were held at their home church. Despite frequently being told by the doctors that "...she's gone...she's at any moment, you just need to go ahead and make your peace with it," the Crafts believed that the hospital personnel were "...not in charge...God is in charge..." We do not know what plans God has for her." Their strong faith in their daughter's recovery was evident: "...we knew our daughter's determination, we knew her will...we knew...that she would fight." Additionally, their strong faith in God's plan provided comfort to face each
new day and provided meaning for the events that occurred, including the death of Stacey's little.

Mrs. Craft described a miracle that occurred during the first two weeks after the accident. "When Stacey was unconscious, she had that ICP probe in, the doctor said he wanted the number to stay below 20. So, I watched it. It kept going higher and higher and higher, and I was a little uncomfortable because nobody knew how to use the probe. I kept going and checking her eyes and doing all these things. And I went out to the desk and asked the nurse to call the doctor because it was going up. And he's a really unusual and old-fashioned doctor so they didn't really want to call him..." Finally, they called him and he said that everything was fine. He said, 'I think the probe is malfunctioning. You need to sit tight. I'll deal with it in the morning.' I knew I was beating the heck out of him. So, I just sat and I had prayed and prayed and prayed until I didn't think I could pray anymore. And then I saw Stacey's shoe that had a message on the bottom of it from Melissa ("Hey Babe, Love Mel")). I put it down on the bed. I just felt a presence and I looked over at the monitor and it was just the high 50s and it goes down and down and down. And it just went by two previously known to the nurses that I prayed for. And that was the shoe that also was on the floor that Stacey had to nudge pain in, so later before she regained consciousness I showed Stacey and she would wear it to bed. You know, the thoughts would always bug about Stacey having so much stamina and so much motivation in therapy, and Stacey would say, 'You know, that's the shoe that my friend wrote that message on,' and it's almost like Melissa was giving her this little push to put her foot up higher and higher... It gave Stacey a lot of encouragement."

As a social-cognitive construct, it is assumed that hope is learned in early and ongoing interactions with role models in the immediate environment. Snyder emphasizes that families are particularly important in supplying messages of hope (Snyder, Clore, & Sigmon, 1997). Parents and other significant adults in a child's interpersonal environment model and teach hopeful thinking strategies for overcoming barriers to goals, reinforcement for working toward goals, and ways to integrate personal with socially acceptable goals (Snyder et al., 1997). Kliewer and Trotz (1993) demonstrated that children's level of hope was directly associated with active coping suggestions from their parents, supporting the impact of parental modeling and instruction on the development of hope. Elliott and Hagen (1997) add that cultural messages of hope can be transmitted through religious accounts and group identity, which provide members with a sense of meaning, purpose, and direction congruent with the values of the group and culture.

It appeared that hope worked as a resilience factor in Stacey's parents. Jim and Martha Craft actively worked and still armed the negative information imposed by the accident and the disability. This type of reaction seems to be common among those with effective reality negotiation strategies (Elliott & Ragland, 1999; Taylor, Collins, Skoel, & Agnall, 1989). Initially, they were hopeful that their child would survive the ordeal. As time progressed and it became apparent that Stacey would survive, they shifted their hope toward the attainment of specific goals such
as regarding consciousness, regaining the use of her arm, regaining speech capacity, and so on.

In this process, hope provided the parents with a sense of direction and meaning, guiding their coping activity and buffering them from profound distress. Family members who find meaning in their caregiving roles after a loved one incurs a disability display less distress (Thompson, 1991). In a compelling study of mothers of children with disability and chronic disease, Horton and Wallender (2000) found that high-hope mothers maintained their emotional balance in times of high stress specific to the child's condition. Furthermore, the relation of hope to maternal adjustment was not mediated by social support.

Hope is consistently predictive of various instrumental coping and coping-related outcome measures (Snyder, Cheavens, & Michael, 1999; Snyder, Symans, Michael, & Cheavens, in press). Problem-focused and other instrumental coping strategies are better predictors of caregiver adjustment following traumatic brain injury than other adaptive mechanisms such as social support (Clifford, 1996). Families that have effective problem-solving abilities in their interpersonal interactions exhibit less distress in cross-sectional research of children and adolescents with acquired brain injuries (Leach, Frank, Bouman, & Farmer, 1994); moreover, these benefits can be observed three years later (Rivera et al., 1996). Family coping behavior soon after the onset of brain injury may be a major determinant of patient behavioral outcomes in the first year of injury (Kimura, Ong, Murugah, Prior, & Satter, 1999).

Jim and Martha Craft worked on tasks that continued to stimulate Stacey while she was unconscious; they played her favorite music, they participated in her movement therapies, they requested religious support, and they reminded staff that, in time, they would see the determination that their daughter possessed.

WHOSE REALITY IS IT ANYWAY? HOPE, STIGMA, AND HELPING-AS-CONTROLLING

As Stacey's coma resolved and she began intense recovery, she began to look toward her future. She stated three goals to family and staff: (1) to walk on her own leg, (2) to graduate with her class, and (3) to graduate with honors. However, according to Stacey’s parents, staff members were uncomfortable with Stacey’s goal-setting and coming toward their attainment.

Shortly before she was to be discharged from the hospital, a discharge meeting, which originally included Stacey’s parents—but not Stacey—was scheduled. Stacey learned of the meeting and asked to attend. The doctor told Stacey’s father that they would discuss her not using... "... and it’s gonna be embarrassing.” Stacey’s father replied, "We’re gonna tell her as you might as well let her be there.” According to Stacey’s mother, during the meeting, the psychologist and speech therapists reported that “she writes like a five-year-old” and so on, with “all staff members giving negative information.” Mrs. Craft recalled that Stacey listened intently for some time and then raised her hand to speak: “I’m not trying to be disrespect-
11 Hope over Acquired Disability: Lessons of a Young Woman's Triumph

fell, but I've been sitting here for ... and, bless her heart, she looked at her watch and it took her [a few minutes]. ... because she had just returned to tell me ... as I do have a future." And they said, "Oh, Stacey, we're not saying that you don't have a future." So, Stacey said, "Well, I just want to know; do you think I'm ever gonna go back to school, will I be able to go to college?" And the doctor said, "I don't know, Stacey, what do you want to do?" And she said, "Well, I've always wanted to be a physician." And they all started laughing. And Stacey said, "Well, I just want to go back to school." And the doctor said, "But, Stacey, you can't read, honey." And she said, "I can get books on tape." And the doctor said, "But, you're not going to be able to take notes, Stacey." And Stacey said, "Well, I can get a note-taker." And the doctor said, "But, Stacey, how are you going to do this?" And Stacey said, "My parents are going to help me." In addition to these reactions at this meeting, staff members noted within the medical record that Stacey's parents were "at a denial/myriad Stacey's prognosis for recovery.

Stacey underwent neuropsychological testing on two occasions, once while she was in the hospital and another time during the summer following the accident. It was the latter set of tests that proved significantly disadvantageous to Stacey and her parents and moved them to question psychology as a profession. Two weeks after the second neuropsychological evaluation was completed, Stacey's parents brought Stacey back to the psychologist for feedback. According to Stacey's mother, the psychologist reported that "if Stacey goes back to school this year, she's not going to be successful." And then all of these emotions that she had never dealt with [regarding the death of her father and everything was going to come all around on top of her and she was going to go into the pit of depression. It was going to be our fault because we were holding her up for it." The staff recommended that Stacey stay out of school for a year. Stacey's parents disagreed and provided the psychologist with a list of recommendations, which included extended time for test taking, a distraction-free environment, providing textbooks on audio-tape, having a note-taker, and so on. Stacey's mother compiled these recommendations after she did research through special education resources and the Internet.

The neuropsychological test results revealed the following: Wechsler Intelligence Scale for Children - III (WISC-III) Full Scale IQ score of 92 (50th percentile); WISC-III Verbal Scale IQ score of 104 (61st percentile); WISC-III Performance Scale IQ score of 81 (10th percentile). Stacey showed wide variability among nonverbal subtest scores, with relatively greater abilities on tests which were not motor-dependent (i.e., Picture Completion Age-Scaled Score of 1.5 vs. Coding Age-Scaled Score of 1). She had residual bilateral dyslexia difficulties. In comparison, there was relatively little variability among her verbal subtest scores.

Other tests were administered within the following specific areas: language, attention/concentration, memory, visual-spatial skills, and achievement. Her language skills were generally within expectations, whereas her attentional abilities and memory were variable, depending on the mode of encoding (verbal vs. visual) and the extent to which other cognitive processes were simultaneously involved (e.g., motor functioning). Visual-spatial functioning was below expectations, primarily due to fine motor difficulties. Her performance on the achievement tests fell within the average to high average range. Overall, Stacey showed cognitive strengths in language areas and relative weaknesses in areas requiring motor and visual scanning abilities.
Although language was an area of strength in this second evaluation, language deficits predominated in the neuropsychological evaluation performed in April, two months after the accident. Direct comparisons cannot be made between the two neuropsychological evaluations because different sets of tests were administered, but it appeared that she had potentially shown some improvement in language over the three months between the evaluations. Given the above test results, which were taken from the testing report provided to the family by the psychologist, it is unclear why it was recommended that Stacy skip a year of school.

The reactions that Stacy and her family received from staff are common. Rehabilitation specialists readily accept maladjustment in a patient who verbally displays any aspect of a maladaptive coping style or who presents unrealistic optimism about his or her condition (Caplan & Sherer, 1987). Clinicians may be more concerned with the potential disruption to routine therapies and intervention plans than the phenomenological perspective of the patient and family. Staff members traditionally lack insight into their own limitations in recognizing healthy coping among persons under extreme stress, because they are trained to serve those who are distressed (Caplan & Sherer, 1987). We have known for some time that people who incur a major loss in life are signified and marked (Harvey & Miller, 1998); unfortunately, professional helpers often participate in this process (Wells, 1998). Psychologists, too, have difficulty recognizing the personal assets, resources, and potentials in clientele (Wright & Fletcher, 1982). Moreover, there is evidence that when professional helpers find that their clients respond unfavorably to their offers of help, they may be quick to disparage the helper (Rosen, Mckee, & Collins, 1987).

High-hope patients may be held in suspicion by staff for other reasons as well. Hopeful patients entering a usual inpatient rehabilitation program, for example, endorsed more functional abilities at admission and endorsed more questions coping styles than low-hope persons (Jackson et al., 1998). One clinician, upon reviewing these data, wondered if this pattern reflected some historic tendencies. Admittedly, hope has been associated with many self-report indices of adjustment, but in association with objective outcome variables among persons with chronic health problems has been inconsistent (for examples, see Bammer et al., 1998; Weith et al., 1997).

Unfortunately, the negative regard of the high-hope person comes at a price to the staff and the client. High-hope people are goal directed. Persons in brain injury rehabilitation programs who actively participate in setting rehabilitation goals maintain their progress months following discharge; those who do not set such goals may regress to baseline levels of functioning (Webb & Glazeleather, 1994). We have found that goal orientation is a powerful predictor of adjustment among persons with recent-onset disability. Those with a high goal orientation evidence less depression and greater acceptance of disability at discharge and greater satisfaction with life one year later (Elliot, Cowate, Lewis, & Palmerton, in press). Additionally, a greater goal orientation is associated with less perceived stigma and greater mobility among community-residing persons with severe disability (Elliot et al., in press, Study 4).
The ability to set and work toward personally meaningful goals may be a key element in the long-term adjustment of persons with disabilities (Segal & Vith, 1971).

Recall that some members of the rehabilitation team described Stacy and her parents as being in denial. It should be noted, however, that Stacey and her parents did not deny the fact of the disability, but rather denied the implications promulgated by the staff (see Lazarus, 1983, for a discussion of these separate denial processes). Nutard & Richards (1991) have argued persuasively that the extant literature on outcomes following traumatic brain injury does not provide rehabilitation staff with a common yardstick or reality, and staff should avoid conflict with family over simple differences in opinion. It should be noted that the pessimistic prognosis could not be made solely on the basis of the available neuropsychological test results that we have reviewed. Faux (1993) has repeatedly criticized the lack of predictive validity of most neuropsychological instruments, and these criticisms may be especially cogent in light of Stacey's preinjury abilities and history of achievement. Assessment results that fall within a relatively normative range—like many of Stacey's—are perplexing in making clinical predictions. A related phenomenon seems to operate in neuropsychological testing, in that outcomes for persons with lower scores may be easier to predict than those with higher, more normative test results (Callahan & Johnston, 1999).

Jim and Martha Craft faced a dilemma: they could deny Stacey's stated goals and consider them either unrealistic or reflecting a lack of self-awareness (often suspected following brain injury) or they could deny the pessimistic interpretations and predictions made by staff and support Stacey in the pursuit of her goals. Jim and Martha decided to support their daughter in her journey of hope.

LIVING WITH THE REALITY: NEGOTIATING THE TERMS

Soon after Stacey regained consciousness, her parents decided to seek out the Stacey's original therapists to give her reading assignments. They decided to stick with these therapists in order to make sure that Stacey's academic work was appropriate for her level of functioning. They also continued to attend the private school system, which was seemingly better equipped to provide an optimal learning environment for Stacey. After exploring the options, including special education through the public school system, summer school, and in-home tutoring, they decided to focus on small group instruction, which seemed to be the most effective for Stacey.

Stacey's mother describes how she and Stacey's father acted to support her during this period: "At first we did all the reading. We went through all the homework, and everything for her . . . and with six weeks we tried to do less and less for her. Once she got this academic, we felt a level of involvement that we wouldn't let you do anything. She would stay up until 2 o'clock in the
morning. And if you said, "Stacey, let me type that for you," she would say, "Mother, you can't go to college with me." And so, she's doing more and more on her own. She is taking notes on her own, but she does not depend on these notes. She has somebody else make notes but she takes notes herself.

Stacey returned to school the fall session following the accident. She has made A's in most classes with the exception of a B in one class. Additionally, she took the ACT test in December of 1998, eight months after the accident, and earned a composite score of 29. She graduated with honors with her high school class in June of 1999, and she accepted an academic scholarship to Johnson University to begin classes in the fall of 1999. She has returned her favorite leisure activity, horseback riding. Although she declined counseling during her rehabilitation program, she reconsidered counseling around the anniversary of the accident this year. She did not want to see a psychologist after her experience in rehabilitation. She decided to work with a Christian counselor. She continues to have difficulty in her leg, and she realizes she will likely need another surgery to help correct the problems with this leg. During our interview, Stacey and her parents each completed the Hope Scale individually. Their Hope Scale scores place them at the high end of the hope continuum. All three individuals indicated that they were satisfied with their lives and that they have gotten the important things they wanted in life so far.

With the help of her family, Stacey achieved her three stated goals. In the pursuit of these goals the Craft family exhibited a sense of agency—goal-directed energy—essential for staying off distressing circumstances that obstruct and block goals. A hopeful person will learn to grovel (Snyder, 1992) and find alternate paths to their goals despite impediments (Snyder, 1998). Once barriers were encountered, the family worked together to find ways around these roadblocks so that her goals could be attained. This included the use of supportive devices and technologies and supportive assistance from her family. These strategies illustrate the characteristics of the pathways component in the hope model (Snyder, 1999). Taken together, we can see that Stacey is moving toward goals that uplift her with a sense of life beyond and despite the physical and cognitive disabilities imposed by the accident. He doing so he fills her life with activities that distract her from her pain (Bondy et al, 1998) and provide her with an identity and purpose independent of her disability (Wright, 1985).

It should be noted that Jim and Marsha took care to provide Stacey with the assistance she needed initially and then slowly tapered off so that Stacey could work and achieve as independently as possible. Stacey, too, realized the need to work independently. Related to this point, Snyder (1998) warns that family members sometimes can provide too much tangible support that over time hope is diminished and disability is increased (i.e., an "imbalance" is reinforced by the family).

Throughout the year, Stacey exemplified her ability to identify and modify goals according to her ability and her circumstances. When considering her choices for college, she chose an institution that could prepare her for medical school. But she also took into consideration that this university (i) had a supportive religious community familiar to her and (ii) had a fairly level terrain that would be easier for her
to navigate. Interpersonal support, access, and mobility were important factors in her decision.

Persons with recent-onset disabilities can have overly optimistic— if not unrealistic— beliefs about their ability to regain lost function for up to a year following injury onset with little or no association with distress or social dysfunction (Elliot & Richards, 1999). But this study also found evidence for an initial optimism: unrealistic beliefs about recovery were moderately associated with distress approximately one year after the onset of disability (Elliot & Richards, 1999). One year following her injury, Stacey too became reflective and concerned about her circumstances. In discussing her thoughts and feelings, it was apparent that she was searching for some sense of meaning in her event, that she missed her best friend, and that she was wondering why she had to endure this accident and injury. Individuals who are caught up in cognitively undoing a traumatic event experience greater distress (Davis, Lehman, Wurman, Silver, & Thompson, 1998). Stacey appropriately sought counseling on her own to help her process through these issues and to refine a sense of personal control in choosing her therapist.

This sense of control over her circumstances and things that happen to her are important characteristics of those who adjust emotionally following disability (Kostenbaum & Ratz, 1977). Finally, Stacey expressed her feelings and emotions about the trauma in her creative writings, and she presented us with many moving poems and essays written throughout her senior year. These emotionally charged expressions are also adaptive, particularly to persons who have experienced trauma (Forerling, L’Abate, Murray, & Pennebaker, 1999).

In some respects, we are not certain how hope affects particular cognitions and emotions to enhance adjustment. Stacey’s experience helps us realize that adjustment following disability is a dynamic process, and for a hopeful person it is an ongoing and active journey. Longitudinal studies that utilize multilevel modeling techniques will help us understand further how characteristics like hope predict adjustment in conjunction with more quantitative devices that capture the individual phenomenological experience of persons with acquired disability. This type of work can help us identify hopeful persons earlier in our rehabilitation programs who might benefit from specialized services that could optimize their abilities. Conversely, learning from the experiences of hopeful persons might enable us to find ways to aid those who have less supportive and less hopeful characteristics.

**Hope is . . . Knowing that, one day**
My body will piece itself back together.

**Hope is . . . Knowing that I will someday**
Overcome my handicap.

**Hope is . . . Knowing that I will**
See Melton again one day.

**Hope is . . . Knowing that God will**
Mend my broken heart.

**Hope is . . . Knowing that I am actually**
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Correspondence concerning this chapter should be addressed to Timothy R. Elliott, Ph.D., ABPP, Rehabilitation Research Center, 1437 North Avenue South, University of Alabama, Birmingham, Birmingham, Alabama 35294. Electronic mail may be sent to telliott@uab.edu.

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