The Psychological and Social Impact of Illness and Disability
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Dr. Stebnicki is also certified by the Washington, DC-based crisis response team, National Organization for Victim Assistance (NOVA), and North Carolina's American Red Cross Disaster Mental Health crisis team. Dr. Stebnicki is an active teacher, researcher, and practitioner with more than 30 years' experience working with the mental health and psychosocial rehabilitation needs of persons who have traumatic stress, chronic illnesses, and disabilities.

Dr. Stebnicki has written eight books, most recent is Disaster Mental Health Counseling: Responding to Trauma in a Multicultural Context (2017, Springer Publishing). He has more than 28 articles in peer-reviewed journals, and has presented at more than 100 regional, state, and national conferences, seminars, and workshops, on such topics as youth violence, traumatic stress, empathy fatigue, and the psychosocial aspects of adults with chronic illnesses and disabilities.

Dr. Stebnicki has served on multiple professional counseling and accreditation boards. He served on the crisis response team for the Westside Middle School shootings in Jonesboro, Arkansas (March 24, 1998), and has done many stress debriefings with private companies, schools, and government employees after incidents of workplace violence, hurricanes, tornadoes, and floods. His youth violence program, the Identification, Early Intervention, Prevention, and Preparation (IEPP) Program, was awarded national recognition by the American Counseling Association (ACA) Foundation for its vision and excellence in the area of youth violence prevention. Other accolades include consulting with former President Bill Clinton's staff on addressing the students of Columbine High School after their critical incident (April 20, 1999).
How fortunate I have been all my life to be loved by two families unconditionally. How lucky to have an abundance of great friends, the privilege to try to inspire and be inspired by thousands of students, and to have close friends and colleagues, such as Mark and Bonnie Stebnicki, on this journey. And how lucky to have my wife and life partner, Darlene, who stubbornly never gave up on me and inspired me to live life large and find my flow.

—Irmo

To my family, who has been with me from the beginning of my career; my wife, Bonnie; daughter, Sarah; and son, Mark; and to a deep friendship with my closest friend and colleague, Irmo, and his wife, Darlene, I owe much gratitude.

—Mark
Contents

Contributors xi
Foreword David R. Strauser xv
Preface xvii
Acknowledgments xix

Share The Psychological and Social Impact of Illness and Disability, Seventh Edition

PART I: HISTORICAL PERSPECTIVES ON ILLNESS AND DISABILITY

1. History of Treatment Toward Persons With Disabilities in America
   Danielle D. Fox and Irmo Marini
   3

2. On the Origins of Negative Attitudes Toward People With Disabilities
   Hanoch Livneh
   15

3. History of Treatment Toward Persons With Psychiatric Disabilities
   Kim Nguyen-Finn
   29

4. Models of Disability: Implications for the Counseling Profession
   Julie F. Smart and David W. Smart
   49

5. Changes in Attitudes Toward People With Handicaps
   Beatrice A. Wright
   69

PART II: THE PERSONAL IMPACT OF DISABILITY

6. Psychological Adaptation to Chronic Illness and Disability: A Primer for Counselors
   Hanoch Livneh and Richard F. Antonak
   77

7. Theories of Adjustment and Adaptation to Disability
   Irmo Marini
   91

8. Psychosocial Disparities Faced by Women With Physical Disabilities
   Margaret A. Nosek
   121

9. Beyond the Binary: Rethinking the Social Model of Disabled Sexuality
   Michael A. Rembis
   141

10. Culture, Family, and Attitudes Toward Disability
    Chia Vang, Sergio Cuevas, Manisha Sharma, and Breeze Rueda
    151

11. Quality of Life and Coping With Chronic Illness and Disability: A Temporal Perspective
    Hanoch Livneh
    173
PART III: FAMILY ISSUES IN ILLNESS AND DISABILITY

12. Family Adaptation Across Cultures Toward a Loved One Who Is Disabled 201
   Noreen M. Graf

   J. Aaron Resch, Gerardo Mireles, Michael R. Benz, Cheryl Grenwelge, Rick Peterson, and Dalun Zhang

14. Psychosocial Counseling Aspects of Grief, Death, and Dying 245
   Mark A. Stebnicki

15. Family Caregiving 257
   Irmo Marini and Michael J. Millington

16. Counseling in the Context of Family Identity 273
   Michael J. Millington and Rosamond H. Madden

PART IV: INTERVENTIONS AND RESOURCES

17. Treatment for Substance Use Disorders 295
   Lloyd R. Goodwin, Jr.

18. Working With Trauma-Related Mental Health Problems Among Combat Veterans of the Afghanistan and Iraq Conflicts 311
   Lindsey N. Cooper, Ryan P. Holliday, Nicholas D. Holder, Jamylah Jackson, Carol S. North, and Alina M. Surís

19. Users of Assistive Technology: The Human Component 345
   Martin G. Brodwin, Frances W. Siu, and Elizabeth Cardoso

20. Religion and Disability: Clinical, Research, and Training Considerations for Rehabilitation Professionals 355
    Brick Johnstone, Bret A. Glass, and Richard E. Oliver

21. Rehabilitation Professionals and Abuse of Women Consumers 371
    Martin G. Brodwin and Frances W. Siu

PART V: NEW DIRECTIONS: ISSUES AND PERSPECTIVES

22. Application of Well-Being Therapy to People With Disability and Chronic Illness 387
    Barry Nierenberg, Gillian Mayersohn, Sophia Serpa, Alexia Holovatyk, Evan Smith, and Sarah Cooper

23. Classifying Functioning, Disability, and Health: The ICF 407
    David B. Peterson

24. From Empathy Fatigue to Empathy Resiliency 425
    Mark A. Stebnicki

25. Obesity as a Disability: Medical, Psychosocial, and Vocational Implications 443
    Maria G. Romero and Irmo Marini

26. Immigrants, Refugees, and Asylum Seekers: The Psychosocial Cost of War on Civilians 459
    Mark A. Stebnicki

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27. Key Concepts and Techniques for an Aging Workforce 471
   Susanne M. Bruyèr, Debra A. Harley, Charlene M. Kampfe, Sara VanLooy, and John S. Wadsworth

28. Risk and Resilience in Military Families Experiencing Deployment: The Role of the Family Attachment Network 485
   Shelley A. Riggs and David S. Riggs

29. Social Justice, Oppression, and Disability: Counseling Those Most in Need 503
   Irmo Marini

30. Reflections and Considerations 521
   Irmo Marini and Mark A. Stebnicki

APPENDIX A: PERSPECTIVE EXERCISES
   Perspective Exercise 1 529
   Common Pain, Mutual Support 529
   Perspective Exercise 2 530
   Who Needs This Kind of Help? 530
   Perspective Exercise 3 530
   Is the Person With a Disability More Important Than the Family? 530
   Perspective Exercise 4 531
   Enough Is Enough 531
   Perspective Exercise 5 531
   Fragile: Handle With Care 531
   Perspective Exercise 6 532
   I Am in Love With a Stranger 532

APPENDIX B: PERSONAL PERSPECTIVES
   Chris and His Mother: Hope and Home 533
      Chris Moy
   Karen—My Daughter Forever 538
      Linda Stacey
   Living in Spite of Multiple Sclerosis 540
      Tosca Appel
   Surviving Amyotrophic Lateral Sclerosis: A Daughter’s Perspective 544
      Judy Teplow
   My Life With a Disability: Continued Opportunities 548
      Paul Egan
   Experiencing Sexuality as an Adolescent With Rheumatoid Arthritis 550
      Robert J. Neumann
   My Life With Muscular Dystrophy: Lessons and Opportunities 556
      Robert P. Winske
   Life Lessons Taught to Me by My Disability 561
      Alfred H. DeGraff

Index 567
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Foreword

In reviewing the seventh edition of *The Psychological and Social Aspects of Illness and Disability* I have come to believe that the publication of this updated edition could not come at a more important time. This book provides a much-needed comprehensive discussion and analysis regarding the importance of the interaction between the psychological and social aspects that impact individuals and their rehabilitation outcomes. One might say that as this book is in its seventh edition, this type of discussion has already occurred. That is true, but the timing of the release of this updated version is important because the text indirectly provides a conceptual framework to guide rehabilitation counseling practitioners and students in developing an understanding of how psychological and social factors interact to impact individuals and their rehabilitation outcomes. In reviewing this seventh edition, several things stood out that make the book important, timely, and a significant contribution to the literature on rehabilitation counseling.

The first thing I did as I examined the text, was to look back at the previous editions and their forewords, several written by Professor Art Del Orto, who was one of the original editors of this book. In Professor Del Orto’s initial edition and subsequent forewords, he provided a very rich review of the emergence of the research related to psychological and social aspects of disability, the key figures in this research, and how this research and those important figures impacted him as a scholar. By reexamining this informative history, one gains an understanding of how this important area of study emerged and has contributed to rehabilitation counseling research and practice. Understanding history is important because it grounds us and helps us appreciate our roots and our identity as a profession. Addressing how psychological and social factors interact with one’s level of functioning to impact societal participation is one of the key pillars that distinguishes rehabilitation counseling from other helping professions. However, one thing that struck me as I was reviewing the seventh edition was how this current text informs the future by providing direction to rehabilitation counseling students, practitioners, and researchers. This text provides new and emerging information regarding how personal and environmental factors interact across the spectrum to impact individuals and outcomes. This text brings to life the *International Classification of Functioning, Disability, and Health* (ICF; World Health Organization, 2001) for rehabilitation counselors and provides contemporary information that can be used to educate, guide practice, and provide the foundation for emerging research related to the psychosocial aspects of disability and chronic disease. Emerging areas, such as working with veterans, refugees, and the aging workforce, along with many others, are covered and provide important information for rehabilitation counselors to use to address the emerging psychosocial issues and needs of the individuals they serve.
Building on my initial reaction, my second thought, maybe even more relevant, was that by indirectly grounding this text in the ICF framework, this book directly minimizes the medical model that unfortunately still guides rehabilitation counseling today. This text highlights the importance of psychological and social factors in human behavior, while eliminating the need to focus on identifying the appropriate and highly valued diagnosis to explain behavior and guide treatment. This text provides rehabilitation counselors with the necessary knowledge needed to conceptualize how personal, environmental, and functioning impact behavior and encourage rehabilitation counselors to develop and implement interventions that leverage resources, empower individuals, and ameliorate environmental barriers. This is in stark contrast to the medical model, which places a premium on establishing the correct diagnosis, using the derived diagnosis as the foundation of treatment, and focusing interventions exclusively on the individual. This difference is important and timely as students, practitioners, and scholars are continually having to deal with mixed messages from professional organizations and accreditation and licensure bodies that may cloak themselves in the guise of rehabilitation values while truly espousing the fundamental tenets of the medical model. This text provides a powerful and informative resource for students, practitioners, and scholars in developing and reinforcing rehabilitation counseling principles that guide rehabilitation counseling education, practice, and research.

Finally, a major strength of this book is its focus on new directions that will impact the provision of rehabilitation counseling education, practice, and research. Providing scholarly discussions of emerging issues, such as empathy resilience, and emerging populations, such as refuges and those who are obese, provides rehabilitation counselors at all levels with important information that will guide future education, practice, and research. In addition, the rich discussion of areas of grief, sexuality, family, culture, social justice, parenting, trauma, veterans, and religion allows students to be grounded in both theoretical and practical issues that impact overall psychosocial functioning. Finally, providing the historical context of how people with disabilities have been treated and the impact of individual and societal attitudes are critical so that emerging trends can be fully appreciated and all levels of rehabilitation professionals have a comprehensive foundation for understanding the psychosocial aspects of disability and the impact that rehabilitation counseling, when guided by conceptually sound principles, can have on maximizing societal participation of those with chronic health conditions and disabilities.

Overall, I would like to offer my sincere appreciation for the editorial work of Irmo Marini and Mark Stebnicki, as they have done a masterful job in collecting a group of chapters that provide contemporary, cutting-edge information regarding psychological and social aspects of chronic health and disability in a historically and theoretically relevant context. This book will become the formative text that guides the education of a new generation of rehabilitation counselors while informing current rehabilitation counseling practice and research. It is important to note that this book provides all levels of rehabilitation counselors with the much-needed resources necessary to begin to fulfill an ICF-based approach to chronic health and disability while minimizing a diagnostically based conceptualization that unfortunately still permeates much of today’s education, research, and practice.

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REFERENCE

Preface

It was the fall of 2010 when we first received a call from Art Dell Orto, the original coeditor of the first five editions of The Psychological and Social Impact of Illness and Disability (1977, 1984, 1991, 1999, and 2007), who asked us to carry on this work. Art indicated that he was not only retiring after an outstanding career at Boston University, but also retiring from many of his professional projects as well. The original edition of this work began with Art Dell Orto, professor, Boston University, and Bob Marinelli, professor, West Virginia University, who edited the first four editions, then Paul Power, professor emeritus, University of Maryland, worked on the fifth edition. Irmo and I have been friends with Art and many of his colleagues over our careers and were flattered, grateful, and honored to be asked to continue editing this exceptional work. When the book first appeared in 1977, few books existed on the topic of psychosocial aspects of chronic illness and disability. Irmo and I had written several chapters in the previous editions of this work based on our research and practice within our careers and were flattered, grateful, and honored to be asked to continue editing this exceptional work. When the book first appeared in 1977, few books existed on the topic of psychosocial aspects of chronic illness and disability. Irmo and I had written several chapters in the previous editions of this work based on our research and practice within this specialty area. However, to be asked to edit and bequeathed this work is much like Captain Kirk of the Starship Enterprise asking Lt. Commander and First Science Officer Mr. Spock to take over the helm. Indeed, this body of work had to continue through the constellation of books on rehabilitation, counseling, and psychology with full thrusters and warp-drive full on.

Irmo hired and mentored me in my first job as an assistant professor in the Department of Psychology and Counseling at Arkansas State University. I was fortunate to be hired directly out of my doctoral program at the Rehabilitation Institute, Southern Illinois University, Carbondale, back in 1995. As any doctoral candidate can attest, it is critical to have good mentors to guide you through the process of teaching, research, and service, and to prepare you for a publish-or-perish job at a teaching institution. It is equally important that one’s first experience in academia also have good mentors to guide one through the real-world experiences of teaching, research, and service.

At my first job in academia, after 11 years of working in rehabilitation, counseling, and behavioral health, I met Irmo, an outstanding mentor; our personalities meshed into one unified brain, we thought, felt, and behaved in the same way on virtually every topic. We never perceived our time together at Arkansas State or currently as simply being “working colleagues”; our friendship runs deep and there are no real boundaries between work and play. It is a culture that few are fortunate to experience, where metaphorically work-is-play and play-is-work. Within a culture like this, the end product usually results in the second edition of a book being better than the first, and the seventh edition being better than the sixth.

This brings us forward to the seventh edition, in which we developed materials based on the talents of many authors and communicated this in a readable and usable...
manner. Approximately two thirds of the chapters are new and/or updated. In keeping with the formula from previous editions, we have maintained the foundation of seminal works of early authors; many present-day authors have leaned on these works for theoretical constructs, models, and practice with the intention of working with persons with chronic illnesses and disabilities. Other sections of *The Psychological and Social Impact of Illness and Disability* feature emerging populations, for whom services are required to support the mental, physical, and spiritual well-being of the individuals and groups who are aged, disabled, or have acquired disabilities because of extraordinarily stressful and traumatic events such as combat, natural disasters, and critical incidents such as terrorism. It also addresses the negative impact of societal inequities, oppression, poverty, and disability on those most in need. Overall, this text addresses the medical, physical, psychosocial, and vocational aspects of a rather unique culture of individuals. Living with chronic illnesses and disabilities is a daily challenge, but one that many meet with resilience and perseverance. It is anticipated that this nexus of material enrich the knowledge, awareness, and skills of both students and instructors in the fields of rehabilitation, counseling, psychology, and the allied health sciences.

Finally, a psychosocial text concerning illness and disability would not be complete without the stories and perspectives of resilient persons with disabilities who have lived the experience. Irmo and I have retained the majority of these poignant personal accounts written by persons with disabilities and/or their loved ones who care for them. Based on these revealing personal accounts and experiences of disability, each section of the book contains keystone and foundational material that has good intentions for learning and professional practice. The Appendices contain exercises to enhance learning. The insights shared in the seventh edition continue to give students and practitioners a different perspective of life with a chronic illness and disability in the United States.

Supplemental materials in the form of an Instructor’s manual and PowerPoint presentations are available for qualified instructors and can be requested by emailing: textbook@springerpub.com
Acknowledgments

We would like to most humbly thank several key people who made this book possible. Editorial Director of Behavioral Sciences extraordinaire, Sheri W. Sussman, who has guided and supported us through several Springer Publishing books, made this experience as stress-free as possible with her sarcastic humor and tremendous wisdom. We would like to also thank Assistant Editor Mindy Chen for diligently keeping us organized, updated, and on time. Accolades as well go to Joanne Jay, VP of Production, and her production team for the nuts-and-bolts support, all in all making yet another Springer product a flawless work of knowledge. A special thank you to a most respected colleague, Arthur Dell Orto, who, after 35 years entrusted us to carry on with his, Bob Marinelli, and Paul Power’s best-selling textbook. Dr. Dell Orto’s numerous book contributions to the field span his career and have elevated thousands of educators and counselors alike in various disciplines. This seventh edition maintains at least a third of these scholars’ previous ideas from earlier editions. We also would like to acknowledge Darlene Marini, who once again took on the tedious task of inputting the reference lists for certain chapters. In addition, Irmo is also appreciative of his two research assistants—doctoral student Breeze Rueda and graduate student Rigel Pinon—their assistance in scouring the literature for the most up-to-date, relevant publications for his chapters. Finally and most important, we acknowledge the select group of authors who have contributed to this seventh edition. Their expertise and field research elevates the social consciousness on disability studies. Similarly, we would like to thank the authors for their personal stories regarding the lived experience of having a disability or sharing a life with someone who is disabled. The seventh edition of this textbook would not have been as successful without these personal perspectives.

Irmo Marini
Mark A. Stebnicki
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The Psychological and Social Impact of Illness and Disability, Seventh Edition
Quality of Life and Coping With Chronic Illness and Disability: A Temporal Perspective*

HANOCH LIVNEH

The concept of quality of life (QOL), as a psychosocial construct, process, measure, goal, and outcome, has gained much popularity in the rehabilitation literature during the past 35 years (Bishop, 2005; Crewe, 1980; Fabian, 1991; Hershenson, 1990; Livneh, 2001; Roessler, 1990). As both a goal (i.e., assisting clients with chronic illnesses and disabilities [CIDs] to attain a better QOL) and a process–outcome indicator (i.e., assessing both subjective and objective levels of QOL during and following rehabilitation interventions), QOL has become one of the most prominent and central concepts in the field of rehabilitation (Bishop, 2005; Bishop, Smedema, & Lee, 2009; Crewe, 1980; Renwick, Brown, & Nagler, 1996). Despite the numerous theoretical, clinical, and empirical perspectives from which it has been approached, the understanding of QOL has seldom been addressed by using the dynamic, time-dependent, process-like perspective of its clinical underpinnings. The link between QOL, as a rehabilitation goal and outcome, and its unfolding temporal link to the domains of (a) community-level clinical interventions (i.e., public health, mental health, crisis intervention, and rehabilitation services) and (b) personal-level coping strategies (i.e., psychosocial adaptation and, more specifically, coping with life stresses and disability-induced functional limitations) has only scarcely been explored by rehabilitation researchers and practitioners.

More specific, within the context of improving and maintaining QOL, community-level interventions have sought to address the occurrence among the public of physical limitations (e.g., functional restrictions), psychological limitations (e.g., stressful life events), and social limitations (e.g., restricted social activities) through the establishment of a comprehensive network of interventions that are geared toward (a) prevention (future oriented; reducing the risk variables that may affect the lives of community members), (b) early intervention (present oriented, or crisis intervention; directed at people who actively experience a crisis by seeking to restore equilibrium and reduce distress), and (c) postvention (past oriented; directed at people long after the onset of stressful or crisis situation, by seeking to minimize residual impairments and limitations following resolution of crisis; Caplan, 1964; Janosik, 1984; Livneh, 1995; Slaikeu, 1990). In a similar

vein, person-level (psychosocial) interventions, mostly internally driven, but, at times, also externally initiated, include the acquisition of individualized coping skills to combat the deleterious impact of disability-imposed functional limitations and associated stressful life events: (a) before crisis onset (i.e., preventive, proactive, and anticipatory coping; or future-oriented coping), (b) during or through currently experienced crisis situations (i.e., crisis intervention, or present-oriented coping), and (c) pursuant to the resolution of crisis (i.e., reactive and residual coping, or past-oriented coping; Aspinwall, 2005; Auerbach, 1992; Folkman & Moskowitz, 2004; Schwarzer & Knoll, 2003).

In line with these notions of community-level and personal-level strategies, the aims of this chapter are to (a) familiarize the reader with the conceptual and temporal parallelism underlying the domains of community interventions and personal coping, of which rehabilitation services are an essential component, as part of their joint goal to improve QOL; and (b) provide examples from the field of psychosocial rehabilitation, and more specific coping with CID, that address the temporal nature of QOL-improving coping strategies.

COMMUNITY AND PERSONAL-LEVEL INTERVENTIONS: MANAGING STRESSFUL EVENTS AND COPING WITH CID

As suggested earlier, an often observed parallelism exists between the temporal undergird of community-level human service interventions and personal-level coping efforts and strategies. The so-called tripartite model of therapeutic modalities, which was first conceived by Caplan (1964) to combat health impairments as well as psychopathologies, was developed to depict prevention and interventions (the two terms are often inexplicably used interchangeably; Auerbach, 1992; Janosik, 1984; Slaikeu, 1990) in the fields of public health, mental health, social services, medicine, nursing, physical therapy (PT), occupational therapy (OT), and rehabilitation (psychology and counseling). The model contains, both structurally and temporally, three distinct content domains as well as time frames. These three intervention domains, as mentioned earlier, are time dependent and customarily include preventive (i.e., primary prevention [PP] or crisis prevention), interventive (i.e., secondary prevention [SP] or crisis intervention), and postventive (i.e., tertiary prevention [TP] or rehabilitation) services. The three domains are also noted by their differential therapeutic goals, indicators, targeted service providers, and intervention strategies (for detailed treatment of various aspects of the tripartite model, the reader may also wish to consult Auerbach, 1992; Goodyear, 1976; Janosik, 1984; and Slaikeu, 1990, and more specifically the rehabilitation field; Hershenson, 1990; Hershenson et al., 1981; Livneh, 1995).

In contrast to the community-based, large-scale, broad-angle view on human health, functioning, and behavior, undertaken by fields such as community health, occupational health, medicine, and nursing, the concept of coping has traditionally been associated more specifically with individual-level processes, originated in the field of psychology and its derivatives (e.g., health psychology, medical psychology, and rehabilitation psychology and counseling). Furthermore, coping models seek to directly address the sources of life stresses by considering their “temporal ordering.” They aim to explore the effectiveness of various coping strategies in minimizing physiological stress, emotional distress, cognitive distortions, and behavioral and psychological dysfunction, as they are anchored in a differentiated temporal fabric (Auerbach, 1992; Schwarzer & Knoll, 2003).

The concept of coping has been explored and described in numerous ways and has been studied in a wide range of contexts (Endler & Parker, 1990; Haan, 1977; Lazarus,
It is essential in the understanding of coping to regard it as a dynamic and sequential process in which the various coping modalities operate, intersect, and aggregate their unique properties (Krohne, 1996; Lazarus & Folkman, 1984; Skinner, Edge, Altman, & Sherwood, 2003). Regardless of its definitional nuances, a common theme that has been overtly or covertly implied by these definitions is that coping efforts undertake different patterns and guises commensurate with the temporal orientation of the encountered stressful situation. Indeed, Auerbach (1992) argued more than two decades ago that time and temporality are intrinsic to the understanding of stress and coping. More specific, he maintained that the two (temporality and coping) are intimately linked because (a) exposure to stressful life events varies in its duration, and as a result, coping outcomes vary as well; (b) stressful life events confront individuals at different developmental life stages, and, consequently, the nature, interpretation, and modes of coping with these events vary along the life cycle (see also McGrath & Beehr, 1990); and (c) life events that occur “off-time” (unexpectedly) typically result in higher levels of stress and less effective coping, as compared with those that occur “on-time” (age-associated) or at a “bad time” concurrent with other life events and stressors (see also Schlossberg, 1981). To this list, one could also add the following: (a) coping (and its success) with stressful life events often hinges on the degree of predictability, certainty, and controllability of the encountered event, and these events differ as to their temporal properties (e.g., unlike a stressful event that has already been experienced, those anticipated are less predictable or controllable; Folkman & Moskowitz, 2004; McGrath & Beehr, 1990; Schwarzer & Knoll, 2003).

The role of temporality in the context of coping with stressful situations was first suggested by Lazarus and colleagues (Lazarus, 1966, 1991; Lazarus & Folkman, 1984; Lazarus & Launier, 1978). In their model of coping with stressful life events, they viewed coping as consisting of a range of psychological and behavioral efforts, undertaken to manage, minimize, overcome, or defuse stressful events. The deployment of coping efforts follows the individual's appraisal of the situation, which determines whether the potential threat is viewed as stressful, irrelevant, or even possibly beneficial for future well-being. These appraisals are further classified as (a) loss and harm (implying events that occurred in the past), (b) crises and ongoing stresses (indicating events of the present), and (c) challenges and threats (implying anticipated or future events). These time-associated stressful experiences further suggest that the temporal location of the stressful event may be associated with certain emotional manifestations such that, for example, appraisals of loss or harm (past orientation) may trigger feelings of depression (and possibly anger), those of threat (future orientation) may be more directly associated with apprehension and anxiety, whereas appraisals of challenge (also future orientation) may be linked to feelings of hope and benefit finding.

In the context of life following the onset of CID, coping efforts, at first glance, seem to suggest that, because CID has already occurred (i.e., the event leading to loss, damage, or injury is anchored in the past), these efforts to mitigate the event's impact should be directed toward the aftermath of the CID. Coping efforts should target overcoming the experience of lost bodily parts, functions, abilities, and so on. In reality, however, this is a rather myopic, misleading perspective because people who have sustained CID, by necessity, must deal with continuous, presently experienced crises and realizations, as well as coping with future consequences and vicissitudes of their physical and psychological conditions. Furthermore, the linear, universal, and objective passage of time in which future events gradually and uniformly mold into the present and then proceed to become part of the past (i.e., Newtonian time) is not reflective of human subjective passage of time (i.e., private or “felt” time) in which time is often experienced through...
cyclical, pendular, episodic, or epochal perception of events, including stressful events, crisis situations, or traumatic onset of CID (McGrath & Beehr, 1990; McGrath & Tschan, 2004; Slife, 1993). For example, a person who sustained a spinal cord injury (SCI), in addition to having to cope with losses (e.g., mobility) and imposed life changes (e.g., use of transportation) and psychological stresses necessitated by the onset of the injury (i.e., the past), in reality must cope with present, continuous stressful situations (e.g., neurological pain, respiratory difficulties, spasticity, urinary complications, inaccessible settings, architectural barriers), as well as anticipated future events (e.g., further medical complications, decreased employment opportunities, increased insurance premiums, and other financial hardships). In a somewhat similar vein, the diagnosis of life-threatening and chronic medical conditions (lung cancer, congestive heart disease) could, likewise, trigger a set of temporally influenced coping efforts, commensurate with the nature, severity, stability, and functionality of the experienced symptoms. For instance, present coping efforts may focus more squarely on mitigating the debilitating effect of anxiety, the impact on other family members, the changes required in daily activities, and the time and energy constraints imposed by the treatment regimen. In contrast, future coping efforts may be differentially applied and focus on long-term implications of the condition, its prognosis, level of (un)certainty and (un)controllability, as well as issues revolving around the anticipated long-term functional abilities and restrictions, financial burden, employability considerations, and future level of QOL. Finally, individuals with early life-induced disabling conditions (e.g., type 1 diabetes mellitus, cerebral palsy, epilepsy) may be altogether more likely to apply a different set of coping efforts, typically termed proactive coping. Individuals with diabetes must regularly proactively cope with such issues as continuous dietary restrictions, worries about future physical complications, fear of diabetic coma and insulin shock, and the anxiety associated with a hidden disability, unpredictable symptoms, and uncertain future. Those with cerebral palsy must also cope, proactively, with such areas as progressively worsening mobility and speech deficits, involuntary muscle spasms (e.g., contractures), feelings of shame and embarrassment, and negative public attitudes triggering social rejection. Finally, people with epilepsy find it necessary to proactively cope with concerns linked to anxiety linked to the unpredictability and often uncontrollability of seizures, the wide range of side effects associated with many antiepileptic medications, social restrictions (on alcohol consumption and driving), and the shame and embarrassment triggered by the seizure itself and the associated public stigma. The use of coping modalities to manage these issues is marked by an early acquisition and organization of those personal and environmental resources needed to facilitate successful coping with the imminent challenges of life with CID and its anticipated, yet often unpredictable, consequences (Aspinwall, 2005; Schwarzer & Knoll, 2003).

In light of the previously noted considerations, the following sections seek to provide the reader with a more thorough review of (a) the role of temporality within community-anchored strategies to combat both physical pathologies and psychopathologies, (b) the role of temporality in coping with life stresses, and (c) selected examples from the CID literature on how temporality has been conceived in assessing coping with, and adaptation to, CID-induced life stresses (Table 11.1).

THE TEMPORAL ASPECTS OF COMMUNITY-BASED STRESS AND CRISIS

Although Caplan’s (1964) original tripartite model of community-based medical and psychiatric pathology prevention was conceived half a century ago, applications of its
<table>
<thead>
<tr>
<th>Comparative Components</th>
<th>Primary Prevention (Prevention)</th>
<th>Secondary Prevention (Intervention)</th>
<th>Tertiary Prevention (Postvention)</th>
<th>Preimpact/Proactive, Preventive Coping</th>
<th>Dynamic/Ongoing Coping</th>
<th>Postimpact/Residual Coping</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time orientation</td>
<td>Future; precrisis</td>
<td>Present; crisis is being experienced</td>
<td>Past; crisis occurred in recent or remote past</td>
<td>Future; precrisis; coping efforts in a planning stage</td>
<td>Present; crisis is being experienced; coping efforts are mobilized and operational</td>
<td>Past; crisis occurred in recent or remote past; coping efforts directed at event aftermath</td>
</tr>
<tr>
<td>Primary goals</td>
<td>Preventing or reducing risk of occurrence of physical and psychiatric impairments</td>
<td>Reducing experienced stressful events and crises, and facilitating psychological growth</td>
<td>Minimizing residual limitations and sustained damage, and restoring adaptive functioning</td>
<td>Preventing or reducing likelihood of occurrence or impact of stress or crisis on one's life</td>
<td>Mitigating psychological toll of currently experienced stress, crisis, injury, or health-impacting diagnosis</td>
<td>Reducing impact of previously sustained life crises and functional limitations, and restoring psychological equilibrium and QOL</td>
</tr>
<tr>
<td>Mechanisms/intervention strategies (examples)</td>
<td>Public awareness and education; health-enhancing environmental modifications</td>
<td>Crisis intervention; psychiatric first aid</td>
<td>Rehabilitation; disability minimization; skill acquisition; environmental manipulation; long-term psychotherapy</td>
<td>Problem-focused coping to prevent or minimize likelihood of crisis; action-oriented coping to avoid exposure to aversive events</td>
<td>Emotion-focused coping to defuse or minimize psychological impact; cognitive-focused coping to contain mental disorganization</td>
<td>Problem-focused coping to manage consequences of crisis; social-emotional coping to defuse affective distress</td>
</tr>
<tr>
<td>Intended/targeted sector</td>
<td>Public; focus on high-risk and more vulnerable groups</td>
<td>Public; family members; affected person</td>
<td>Affected person</td>
<td>Affected person</td>
<td>Affected person</td>
<td>Affected person</td>
</tr>
<tr>
<td>Practicing professions</td>
<td>Educators/teachers, public and occupational health providers, preventive medicine practitioners</td>
<td>Physicians, nurses, psychotherapists/mental health counselors, police officers</td>
<td>Rehab. psychologists and counselors, PTs, OTs, rehab. engineers</td>
<td>NA; crisis survivor and family</td>
<td>NA; crisis survivor and family (possibly psychotherapists and clinical rehab. and mental health professionals)</td>
<td>NA; crisis survivor and family (possibly mental health and rehab. professionals)</td>
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<tr>
<th>Comparative Components</th>
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<th>Dynamic/Ongoing Coping</th>
<th>Postimpact/Residual Coping</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stressful life events and crises (examples)</td>
<td>Genetic susceptibility; environmental pollutants and carcinogens</td>
<td>Injuries, accidents, natural disasters</td>
<td>Long-term/chronic CID, residual functional limitations and deteriorating health conditions</td>
<td>Age-related diseases and functional losses, retirement, upcoming medical treatment/surgery</td>
<td>Physical injuries, vehicular accidents, life-threatening diagnoses or illnesses, Victimization events</td>
<td>Aftermath of CID, aftermath of personal losses, long-term impact of bodily injuries or psychological traumas</td>
</tr>
<tr>
<td>Locus of intervention-initiating agent</td>
<td>External (environment; other people)</td>
<td>External and internal (person)</td>
<td>External and internal (person)</td>
<td>Internal (person)</td>
<td>Internal (person) and possibly external (other people)</td>
<td>Internal (person) and possibly external (other people)</td>
</tr>
<tr>
<td>Rehabilitation-related applications</td>
<td>Promoting physical and mental health; expanding and strengthening social networks; ensuring occupational safety practices; bolstering QOL among people with CID</td>
<td>Providing crisis-oriented, psychiatric first aid type services to reduce distress; gradually restoring cognitive and emotional functioning</td>
<td>Minimizing CID impact through use of assistive technologies; teaching and practicing life skills necessary to overcome CID impact, modifying and restructuring physical and social environments</td>
<td>Practicing coping (and building coping resources) to thwart or minimize likelihood of future disease/CID occurrence and exposure to aversive events and CID impact; striving to maintain accustomed levels of QOL</td>
<td>Applying available coping strategies to mitigate psychological/emotional impact of ongoing crises, such as injuries, accidents, painful sensations, and life-threatening diagnoses; gradually restoring previous levels of QOL</td>
<td>Applying available coping strategies to defuse and manage long-term consequences of CID, including chronic functional limitations, impaired vocational abilities, and long-lasting emotional distress; bolstering positive-oriented coping to regain pre-CID QOL</td>
</tr>
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CID, chronic illness and disability; OTs, occupational therapists; PTs, physical therapists; QOL, quality of life; rehab., rehabilitation.
clinical acumen and practical versatility have been surprisingly lacking in the fields of rehabilitation psychology and counseling. In this section, we provide an overview of the model’s three-pronged temporal nature (i.e., PPs, SPs, and TPs/interventions) and essential features.

**PP**

PP encompasses those strategies that seek to reduce, harness, and, if possible, prevent the occurrence of physical disabilities, chronic illnesses, and psychiatric disorders among members of the public, with particular emphasis on those who represent high-risk groups, thus ensuring a sustained positive QOL. They are, therefore, applied before the event occurrence. When viewed from a different angle, as espoused by the prevailing positive psychology framework, these interventions may also be said to represent attempts at promoting physical and psychological health, as well as positive QOL (e.g., subjective well-being, life satisfaction). The professions that best represent the type of interventions within the PP domain include, among others, public/community health, public education, occupational health, public safety, and preventive medicine. Specific intervention strategies most commonly used by proponents of PP, therefore, include public education and political campaigns to inform the public of health threats and hazards; environmental modifications to ensure the reduction, control, or elimination of detrimental environmental stimuli and stressors; and the teaching and promotion of behaviors that are known to be successfully linked to warding off future stressful situations and physical impairments and diseases. On a more constricted scale, PP strategies focus on teaching problem-solving and decision-making skills and the fostering of personal strengths, resources, and coping modalities that serve to immunize people to stress and minimize the future risk of physical and psychiatric conditions (Caplan, 1964; Hershenson, 1990; Livneh, 1995; Slaikeu, 1990).

**SP**

SP, or *crisis intervention* (also referred to as direct or real-time intervention), refers to those interventions that attempt to directly, immediately, and intensely reduce the effects of an ongoing life (non-chronic) crisis, and, concomitantly, promote personal resilience and growth through the crisis experience itself. Through these early intervention efforts, SP aims at restoring life equilibrium and reducing the severity and frequency of debilitating affective, cognitive, and behavioral distress experienced by community members. Crisis intervention, therefore, is equated with those efforts more traditionally referred to as short-term (crisis) therapy, intensive psychotherapy, and psychiatric first aid (Auerbach, 1992; Caplan, 1964), which aim to restore previously experienced QOL. The professional schools that most clearly represent SP interventions are medicine and nursing (i.e., urgent care), and psychiatry and psychotherapy, all seeking to reverse or curtail physical pathology (medicine and nursing) and psychiatric symptomatology (psychiatry and psychotherapy). Unlike PP, where the focus is on the community at large, SP targets selected individuals directly (i.e., those affected by the crisis experience), as well as their immediate environments (Hershenson, 1990; Livneh, 1995).

**TP**

TP, also known as *postvention or rehabilitation*, is the third and final domain (as well as therapeutic phase) of community-based intervention. It encompasses those interventions that are geared toward minimizing and, if possible reversing, the residual impact on people (typically patients or ex-patients) of long-standing and severe physical and psychiatric CIDs, whose onset has been associated with an earlier experience of crisis.
and its aftermath. TP is implemented long after crisis resolution (although it may be initiated relatively early following successful attainment of physical and/or psychosocial equilibrium), and its overarching goal is the restoration of pre-CID QOL. When put differently, TP focuses on the provision of supportive and ameliorative services to individuals with CID and the promotion of a better QOL (Bishop, 2005; Hershenson et al., 1981; Janosik, 1984; Livneh, 1995; Slaikeu, 1990; Wright, 1980). Among the professions that are associated with TP, the most prominent ones are medicine (for chronic conditions, psychiatry, cardiology, neurosurgery, oncology, pain medicine), long-term psychotherapy, PT, OT, speech and hearing therapy (S&HT), rehabilitation engineering, and (psychosocial, vocational) rehabilitation psychology and counseling (Hershenson, 1990; Livneh, 1995).

Further analysis of the goals of TP, as mostly espoused by the fields of rehabilitation psychology and counseling, indicates that they could be further categorized into the following three domains.

**CID Minimization**

This goal is best reflected in those efforts that seek to minimize the CID impact on the individual by reversing the course of the CID and restoring functional capacity, including affected life skills. Typical interventions include the use of assistive technologies to improve sensory functioning, surgical procedures to correct neuromuscular and orthopedic impairments, the use of orthotic and prosthetic devices to improve mobility and manipulative functioning, and a host of CID-specific PT, OT, and S&HT procedures (Hershenson, 1990; Livneh, 1995).

**Skill Acquisition**

This goal is normally associated with rehabilitation efforts to compensate for the functional limitations imposed by CID through the enhancement of other, not directly implicated abilities and skills, thus often necessitating modification and reformulation of earlier life goals. More specifically, the goal is to teach and practice specific coping skills and a broad range of life skills through the adoption of psychosocial and vocational rehabilitation (VR)-based strategies that include educational, career, vocational (job-specific), and personal adjustment skills. Among the wide spectrum of coping skills training modules available, the following appear to be the most widely used: managing anxiety, depression, frustration, and anger; self-assertiveness; stigma reduction; self-concept/efficacy improvement; job searching, interviewing, and performance; time management; decision making; problem solving; money management; and medical/symptom management. Rehabilitation (postvention) services are commonly provided by rehabilitation counselors and psychologists, special educators, social workers, and recreational therapists (Hershenson, 1990; Livneh, 1995).

**Environmental Manipulation**

This goal is normally implemented through efforts directed at modifying and restructuring the environment to minimize the impact of CID-imposed functional restrictions. These efforts are aimed at both the physical environment (i.e., restructuring features of one’s home, work, and leisure activity environments and eliminating community-based architectural barriers) and the social/attitudinal environment (i.e., combating and eliminating the stigma, prejudice, and discrimination stemming from the existence of CID). The target groups include family members, employers, and members of the public whose negative attitudes often foster additional barriers to positive QOL maintenance (Hershenson, 1990; Livneh, 1995).

In sum, the community-based primary, secondary, and tertiary interventions are mostly externally driven strategies (i.e., applied by trained professionals) geared toward
preventing or minimizing the likelihood of occurrence, or reducing the impact of certain medical and psychiatric conditions before, during, or following their onset. In addition, although a logical temporal sequencing is often assumed for strategy applications (i.e., prevention → intervention → postvention), strategies normally applied later on in this model are not necessarily bound by these clinical features. People who sustained CID (by definition, function in a postvention or rehabilitation stage) are not excluded from using, and are just as likely to benefit from, preventive and interventive services for QOL enhancement that may stem from anticipated future medical complications and encountered crisis situations that may still be experienced by the person with CID.

THE TEMPORAL ASPECTS OF COPING WITH STRESS AND CID

Only scarce literature is presently available on the temporal aspects of coping efforts. Nevertheless, this body of literature suggests that these efforts to improve QOL following stressful situations (e.g., onset of CID) could be conveniently organized into three broad categories: (a) preemptive, or preimpact, coping efforts that are directed at potential future stressful live events (threats, challenges) that range from those whose occurrence spans from unlikely but possible to likely or probable; (b) crisis-experienced coping efforts directed at presently experienced, or ongoing (dynamic), stressful events and crises (including various physical injuries, bodily insults, and psychiatric crises); and (c) postimpact or postevent coping efforts directed at stressful life events (losses, harms) of the past whose impact still plays a significant role in influencing present physical, psychological, and social activities (Aspinwall, 2005; Auerbach, 1992; Livneh & Martz, 2007; McGrath & Beehr, 1990; Schwarzer & Knoll, 2003).

Preemptive or Preimpact Coping

Preemptive coping can be viewed as the person-level analogue of community-anchored PP, which, as outlined earlier, aims to reduce the likelihood of future occurrence of both physical and psychiatric CIDs. Preimpact coping strategies have been classified into the following: (a) preventive coping, regarded as the most temporally distal from future event occurrence; (b) proactive coping; and (c) anticipatory coping (most proximal to future event occurrence). Put differently, the extended preimpact period can be, somewhat arbitrarily, subdivided into distal anticipatory (preventive), mid-range anticipatory (proactive), and proximal anticipatory (or just anticipatory) “time zones” (Auerbach, 1992; McGrath & Beehr, 1990; Schwarzer & Knoll, 2003). As a group, all preemptive coping efforts present a rather elusive and uncertain picture because the impact or stressful experience has not yet occurred and is, therefore, not directly familiar to the person. These efforts, then, may be conceived as attempts to cognitively scan possible future scenarios and the scope of their potential impact and implications, and gradually build up (psychologically and behaviorally) those necessary resources to combat stressful life events.

Preventive Coping

Preventive coping, as its name suggests, focuses on those long-term, distant future-anchored, yet broadly anticipated events well before these events are to be encountered (e.g., retirement, age-related illnesses, expected functional losses, long-term medical insurance). These efforts, therefore, reflect coping strategies that seek to address uncertain and mostly unpredictable threats located within a distant future. The function of preventive coping, according to Auerbach (1992), is to ideally delay or, when feasible, prevent the likelihood of (a) the event occurring, (b) the impact of the event on the individual, and (c) the potential damage that the impact of such an event may impose on
the individual. In the context of the health domain, Auerbach further argues that activities undertaken by the individual during preventive coping typically include (a) prevention of the occurrence of these potentially stressful or damaging events (e.g., the use of problem-focused coping); (b) prevention of exposure to those potentially aversive events, such as the use of problem-focused and action-oriented coping to avoid such exposure (e.g., carcinogenic agents, pulmonary pollutants, hearing loss-inducing environments); and (c) prevention or, at the very least, significant minimization of the detrimental consequences of such potentially damaging and stressful events, again, through the employment of mostly problem-focused efforts that seek to eliminate or reduce anticipated harmful conditions, various life losses, functional limitations, and experienced pain.

In a similar vein, Schwarzer and colleagues (Aspinwall, 2005; Schwarzer, 2000; Schwarzer & Knoll, 2003) have maintained that preventive coping is noted for its efforts to prepare the individual for adverse or stressful events through the gradual building and use of generalized resources (e.g., development of psychological strengths, accumulation of wealth, attainment of social resources and skills). These future-oriented efforts are directed at nullifying (or, at times, mostly minimizing) the severity of the potential impact and maximizing the probability of successful stress-reducing strategies.

**Proactive Coping**

Whereas preventive coping, ideally, seeks to avoid or neutralize the occurrence of potentially threatening stressful life events, proactive coping efforts focus more on minimizing or reducing the impact of such future-anchored events (i.e., events that are likely to occur). The available literature, however, is not always clear about such a distinction and presents a rather overlapping view of the two coping modalities. For example, Aspinwall and colleagues (Aspinwall, 2005; Aspinwall & Taylor, 1997) offer only marginal distinction between proactive and preventive coping efforts and regard both as active behavioral efforts to prevent, eliminate, reduce, or modify impending stressful events. The latter encompass events such as threatening environmental situations or taxing psychological demands, which are likely to culminate in harm, loss, or damage.

As compared with anticipatory coping (discussed in the next section), proactive coping can be best described as (a) temporally removed from the threatening event (i.e., they are used earlier in the chain of coping efforts); (b) invoking aggregation of personal and environmental resources, including the mastery of skills needed to confront threatening events; and (c) necessitating a different set of coping skills. Although proactive coping is normally better served through the use of more active coping modes, such as planning, information gathering, skill development, and goal management, anticipatory coping may, quite often, be better served through the use of more affective and social coping modes, such as emotional regulation, emotional support, and positive reappraisal to manage the upcoming stressful event (Aspinwall, 2005; Aspinwall & Taylor, 1997).

A somewhat diverging perspective was advanced by Schwarzer and Knoll (2003; Folkman & Moskowitz, 2004). These authors view proactive coping as coping efforts that involve future challenges that are “potentially self-promoting” (Folkman & Moskowitz, 2004, p. 757; Schwarzer & Knoll, 2003). In contrast, they regard preventive coping as coping efforts that portend “an uncertain threat potential in the distant future” (p. 757). Proactive coping, therefore, serves as the prototype of positive coping efforts, in which the individual builds up resources that facilitate promotion of challenging future goals and personal growth, as well as goal management and the attainment of meaningful life pursuits (Schwarzer & Knoll, 2003). These efforts, then, serve a different purpose than the one promoted by preventive coping, the latter seeking to avoid or largely minimize potential negative occurrences, such as damage to one’s physique or psyche.
Anticipatory Coping
As its name implies, anticipatory coping refers to those coping efforts that are triggered by environmental and physical (e.g., bodily) cues that indicate that the individual is on a course of confronting, in the near future, an aversive life event (e.g., anxiety-provoking doctor appointment, forthcoming diagnostic test or surgery, job interview, important exam, upcoming retirement) with a high degree of certainty (Auerbach, 1992; Folkman & Moskowitz, 2004; Schwarzer & Knoll, 2003). Here, too, the individual may be more likely to use problem-focused coping to avoid such an encounter or, if this is impossible, to minimize the risk or damage (including level of stress) that such an encounter may produce (Auerbach, 1992; Janis, 1958).

Anticipatory coping is further subdivided into those efforts that confront avoidable and unavoidable life stressors (Auerbach, 1992). A somewhat similar subclassification may also be useful here, in which future life stressors are grouped into controllable and uncontrollable, changeable and non-changeable, certain and uncertain events (Krohne, 1993; Maes, Leventhal, & de Ridder, 1996; McGrath & Beehr, 1990; Mishel, 1988; Perrez & Reicherts, 1992). Avoidable (or potentially controllable) stressors according to Auerbach and others (e.g., Aspinwall & Taylor, 1997; Schwarzer & Knoll, 2003) are those stressors whose potential harm can be modified, minimized, or postponed. This can be accomplished through vigilant attention, preparation for the stressful event's eventual occurrence, acquisition of necessary information, assessment of useful alternatives, and selection of an appropriate course of action to confront those upcoming stressors. Unavoidable, or uncontrollable, stressors, however, such as eventual retirement, physical deterioration, death of spouse or oneself, and even the risk of invasive medical and surgical procedures, are those stressors that most, if not all, individuals ultimately face. According to Auerbach (1992), successful coping efforts with these imminent stressors include both cognitive-behavioral-focused modalities (e.g., information use, planning, behavior modeling) and emotional-focused modalities (e.g., seeking social support, venting emotions in a supportive environment) used to reduce apprehension, anxiety, and further stress.

Dynamic or Impact-Experienced Coping
Coping with ongoing crises may be considered the individual-level analogue of community-aimed SP, the latter seeking to mitigate the psychic toll mounted by a presently experienced crisis situation (e.g., injury, life-threatening diagnosis). Dynamic coping, or coping with presently experienced stressors or crises, includes those coping efforts where the individual is said to actively manage the stressful event. They are also described as coping efforts undertaken during (at the present, or at real time) directly experienced, or ongoing, stressful events, often also termed crisis or crisis situation. Ironically, crisis is often viewed as that period where coping, including problem-solving ability, has broken down, and, therefore, normal coping and cognitive processes are no longer capable of achieving the goal of returning the individual to a state of psychological equilibrium (Roberts, 2000; Slaikeu, 1990). The redeployment of organized and balanced coping efforts is not an instantaneous and automatic occurrence and may, therefore, require additional time to successfully detect, interpret, process, and eventually recover from the crisis experience (McGrath & Beehr, 1990). Notwithstanding this theoretical contradiction, one of the primary aims of coping efforts that ostensibly still serves the individual in crisis is to defuse or minimize the felt (emotional) impact (Hodgkinson & Stewart, 1991; James & Gilliland, 2001).

Historically, the field of coping with crisis situations has its roots in the seminal bodies of work of Eric Lindemann (1944) and Gerald Caplan (1961, 1964). Lindemann studied reactions of acute grief and bereavement among both nonpsychiatric and
psychiatric patients, describing them as reflecting wave-like processes of panic and anxiety reactions that alternate with those of denial and avoidance. In his Crisis Prevention/Intervention model, Caplan extended this body of work by developing a crisis-oriented brief psychotherapy to help individuals who experience a crisis to better confront and defuse their stress reactions during this time-limited period.

It is beyond the scope of this chapter to address the plethora of contributions made by crisis (and crisis intervention) clinicians and researchers. Briefly, however, it could be argued that to better understand crisis-experienced coping, one needs to (a) provide a broad description (rather than the formal, yet linguistically rigid, use of a succinct definition) of the term crisis that includes its main components and clinical features, (b) understand the initial and extended reactions to crisis, and (c) describe the primary types of crisis. These are summarized in the following paragraphs for the benefit of readers who are not well-acquainted with the literature on crisis intervention.

The Experience of Crisis

There have been many, and often inconsistent, definitions of the term crisis. It may, therefore, be beneficial to provide first a more general description of the term. Briefly, then, crisis can be described as a subjective reaction to an acute and intense variant of a stressful or hazardous life event or experience. By its very nature, it has an identifiable beginning (a precipitating event, or an adverse stimulus or catalyst) and is a time-limited (i.e., temporary) state; a state most commonly associated with cognitive and emotional disorganization, psychological disequilibrium, extreme vulnerability, reduced functional capacity, and ultimately a failure to cope with the stressful situation using previously familiar and successful strategies. Crisis, then, reflects the experience of a highly stressful situation or event that creates an obstacle to the attainment of meaningful life goals, and whose resolution exceeds the individual’s presently available resources and coping (i.e., problem-solving) strategies (Collins & Collins, 2005; James & Gilliland, 2001; Janosik, 1984; Roberts, 2000; Slaikeu, 1990). Other models of crisis can be found in Selye’s (1976) general adaptation syndrome (alarm, resistance, and exhaustion) and Horowitz’s (1986) stages of normal response (outcry, denial, intrusion, working through, and completion) versus pathological response (overwhelmed, panic, exhaustion, avoidance, flooded psyche, and psychosomatic response) to crisis situations.

Reactions to Crisis

The clinical literature has generated an exhaustive list of chaotic psychosocial reactions that are associated with the onset of crisis. Among the most frequently discussed are those that indicate cognitive and emotional distortions and behavioral malfunctioning. More specifically, the literature strongly indicates that acute reactions to crisis situations strongly parallel those observed among individuals who sustained a sudden and severe onset of CID, and that have traditionally been referred to as shock, alarm, and anxiety “phases” (alternatively referred to as reactions or responses; Hodgkinson & Stewart, 1991; Horowitz, 1986; Livneh & Antonak, 1997; Shontz, 1975). These include reactions such as disbelief, numbness, confusion, disorientation, incoherency, feeling overwhelmed, disorganized thinking and speech (all regarded as indicators of a shock response), intense fear, panic, tension, distress, subjective discomfort, and dread (all viewed as indicators of an anxiety response; Caplan, 1964; Cavaiola & Colford, 2006; Collins & Collins, 2005; James & Gilliland, 2001; Janosik, 1984; Roberts, 2000; Slaikeu, 1990). These reactions are perceived among “crisis theory” proponents as further clinical proof that during the
immediate aftermath of a crisis experience, the person is temporarily unable to cope. This eventuality is believed to follow the breakdown of the network of previously used coping strategies that are now incapable of thwarting off crisis-triggered cognitive and affective disorganization.

Types of Crisis

Crisis situations are commonly subdivided into the following types.

**Developmental crises.** These are crises that are associated with those life stages or phases (the life cycle; for example, Erikson's psychosocial stages of development) that the individual undergoes, rather predictably, during the normal course of his or her growth and maturation. They reflect changes perceived in the individual's inner sense of self as he or she transitions through these life milestones (James & Gilliland, 2001; Janosik, 1984; Slaikeu, 1990). Examples include high school or college graduation, marriage, career change, “midlife crisis,” and retirement.

**Situational crises.** These are crises that are directly linked to sudden onset, random, unexpected, unpredictable, uncommon, and environmentally triggered episodes, where the individual faces external events that may alter his or her life considerably and even permanently (James & Gilliland, 2001; Janosik, 1984; Slaikeu, 1990). Examples include (a) health-related crises, such as loss of body part or function, major surgery, physical injury, automobile accident, and life-threatening illness (or its diagnosis); (b) death-related crises, such as the death (by natural causes or fatal accidents), homicide, or suicide of a spouse or a loved one; (c) crime-related crises, such as physical or sexual assault, domestic violence, and any other form of victimization; (d) financial crises, such as job loss, bankruptcy, and loss of one’s home; and (e) crises associated with natural or man-made disasters, such as earthquakes, floods, hurricanes, fires, and wars (James & Gilliland, 2001; Janosik, 1984; Slaikeu, 1990).

**Existential crises.** These crises are the result of personal anxieties and inner conflicts that are associated with significant and unresolved human issues and uncertainties. These experienced crises typically reflect subjective concerns that include, among others, the purpose and meaning (or alternatively, futility) of one’s life and existence, personal responsibility, issues of dependency versus independency, freedom and freedom of choice, alienation, commitment (to others or an important cause), and connectedness to others (Cavaiola & Colford, 2006; James & Gilliland, 2001).

Postimpact Coping

Postimpact coping can best be seen as the person-level analogue of community-based TP, which embodies rehabilitation philosophy and processes and focuses on reducing and altering functional limitations acquired in the most recent as well as remote past; therefore, their resolution culminates in enhanced QOL. Postimpact, or postcrisis, coping has been traditionally viewed as including two temporally variant coping efforts. These are (a) proximal or reactive coping efforts (where the impact of harm, damage, loss, or onset of CID has been sustained within recent time), and (b) distal or residual coping efforts (where these events occurred more remotely in time; Auerbach, 1992; Folkman & Moskowitz, 2004; Livneh & Martz, 2007; Schwarzer & Knoll, 2003). No clear demarcating boundary between what is regarded as “recent” or “short-termed” and what is referred to as “remote” or “long-termed” has ever been proposed in the literature. Despite the fact that reactive coping is directed toward experiences of the immediate (short-term) past, and residual coping toward experiences long after the stressful event
has occurred, in both cases primary coping strategies often include (a) problem-focussed coping to manage the consequences of the event (e.g., task-oriented), (b) cognitive-focussed coping to rationally assess and prioritize available alternatives (e.g., cognitive reappraisal, belief-control, meaning finding, and benefit finding), (c) social-emotional coping to defuse or moderate emotional distress and heightened anxiety (e.g., seeking social support, expressing emotions constructively), and (d) avoidance coping to divert or remove oneself from a stressful situation (e.g., social avoidance, denial, emotional venting; Amirkhan, 1990; Endler & Parker, 1994; Martz & Livneh, 2007; Moos & Holahan, 2003; Pearlin & Schooler, 1978).

Traditionally, therefore, postimpact coping can be viewed as coping efforts directed at stressful events whose aftermath resulted from physical harm or bodily injury, personal loss (e.g., marital breakup, job loss, loss of home), and, in general, chronic illnesses or disabling conditions that were experienced in the immediate or remote past and that, consequently, served to mitigate against negative affect and restore functioning and pre-impact QOL (Bishop, 2005; Kennedy, Lude, Elfström, & Smithson, 2012; Livneh, 2001; Moos & Holahan, 2007; Smedema, Catalano, & Ebener, 2010). The goal of postimpact coping efforts is, accordingly, to compensate for those sustained losses and injuries and gradually restore psychological equilibrium, leading to an improved QOL (Bishop, 2005; Bishop et al., 2009; Schwarzer & Knoll, 2003). Postimpact coping efforts could, therefore, be regarded as more realistic and tangible in nature, as compared with preemptive efforts, because the impact has already been experienced, perceived, and cognitively and emotionally processed. In the context of life following the onset of CID, these efforts could also, at first glance, be viewed as dealing with shattered plans and hopes, and essentially with the discrepancy created between “having had” (the past) and “no longer having” (present and presumably future).

In sum, then, the person-based preemptive, dynamic, and postimpact coping efforts are mostly internally derived strategies (i.e., applied by the individual himself or herself) geared toward preventing or minimizing anticipated future stressful events, confronting ongoing crisis situations, and managing the aftermath of past stressful occurrences and related CID-triggered losses. In addition, although a logical temporal sequencing is often assumed for the application of these coping modalities (i.e., preemptive → crisis-experienced → postimpact), strategies normally applied later on in this model are not necessarily restricted to this order. People who sustained personal losses, including CID (by definition, engage in postimpact coping), are not excluded from using, and are just as likely to benefit from, preemptive and crisis-experienced coping strategies that may stem from anticipated future stressful events and ongoing crisis situations that may still confront the person with CID. Indeed, research findings have shown that past-oriented coping efforts (or “getting stuck” in the past, focusing on the negative content of the past) and foreshortened future time coping (failure to project into the future) are often associated with negatively valenced coping and increased levels of psychological distress (e.g., Buckelew, Baumstark, Frank, & Hewett, 1990; Holman & Silver, 1998; Livneh & Martz, 2007; Malcarne, Compas, Epping-Jordan, & Howell, 1995; Martz, 2004). Similar findings were obtained from the literature on the relationships between negative past-oriented appraisals and psychosocial outcomes following the onset of CID. For example, appraisals of loss, including overwhelming disbelief of SCI occurrence and related negative perceptions of its impact on one’s life, have been associated with higher levels of depression and anxiety, poorer social integration, and lower QOL perceptions (Dean & Kennedy, 2009; Kennedy et al., 2012; Kennedy et al., 2010). Other indicators of negative and past-oriented appraisals, including feelings of helplessness (lack of control over the future) and self-blame (focusing on self in the past), have also been found to be correlated with
perceived lower QOL and life satisfaction, and even self-reported poorer mental health (Schulz & Decker, 1985; van Leeuwen et al., 2012). In a similar vein, a burgeoning body of literature has now been amassed to document the beneficial consequences, including the salutary influences on various QOL indicators, of future- and positive-oriented coping on the lives of people with CID. These are reviewed subsequently.

Coping: Gaining From Adversity

As was argued earlier, the more traditional view of coping fails to fully recognize two important issues. First, postimpact coping is not necessarily bound by a past-oriented psychological framework, and second, it does not indubitably originate from a “loss and grief” mentality. To wit, postimpact coping efforts are not necessarily constricted in their focus to negative perceptions, cognitions, and feelings that are tied to lost past abilities and unfulfilled dreams. Indeed, adopting a future-oriented, positively valenced coping framework, rather than a past-oriented, negatively valenced approach to coping, negates focusing not only on the immutable past and therefore losses incurred, but also, and most importantly, on the future and its many opportunities for personal growth and improvement in one’s QOL. A growing body of literature has now conclusively documented that the onset of CID often gives rise to positive perceptions and beliefs that, alternatively, are linked to new hopes, aspirations, and challenges. These latter positive appraisals and adaptive coping modalities have been shown to be associated with such psychosocial outcomes as psychological and social QOL, life satisfaction, and perceived well-being, and negatively linked to depression and anxiety. They have been studied and observed under terms such as maintaining hope (Elliott, Witty, Herrick, & Hoffman, 1991; Kennedy, Evans, & Sandhu, 2009; Kortte, Stevenson, Hosey, Castillo, & Wegener, 2012; Snyder, Lehman, Kluck, & Monsson, 2006); benefit finding (from adversity in general and CID, more specifically; Helgeson, Reynolds, & Tomich, 2006; Kortte, Gilbert, Gorman, & Wegener, 2010; Pakenham, 2005; Tennen & Affleck, 2002; van Leeuwen et al., 2012); meaning searching, making, restoring, or finding (Davis & Morgan, 2008; Davis, Nolen-Hoeksema, & Larson, 1998; deRoon-Cassini, de St Aubin, Valvano, Hastings, & Horn, 2009; Janoff-Bulman & Yopyk, 2004; Pakenham, 2007; Park, Edmondson, Fenster, & Blank, 2008; Park & Folkman, 1997); purpose or meaning in life (deRoon-Cassini et al., 2009; Reker, 1977; Thompson, Coker, Krause, & Henry, 2003); posttraumatic growth (or growth and resilience through adversity; Joseph & Linley, 2006; Kennedy et al., 2010; Pollard & Kennedy, 2007; Tedeschi & Calhoun, 2004; Tedeschi, Park, & Calhoun, 1998); and challenge (used as a generic term for Lazarus-derived, future-oriented, primary appraisal concept; Kennedy et al., 2009; Kennedy et al., 2012).

These coping efforts demonstrate that postimpact coping, despite its origination from a stressful and loss-associated past event, nevertheless is not bound by past orientation and, frequently, spans the entire range of the human temporal experience. When put differently, the post-CID experience often necessitates the engagement of both proactive (e.g., anticipating future barriers, transcending life constraints) and presently active (e.g., confronting ongoing stresses and restrictions, defusing negative affective states) sets of coping efforts to restore perceived pre-CID QOL, or any QOL level commensurate with one’s present abilities, skills, plans, and hopes. Indeed, research focusing on future-oriented, positive postimpact coping, as manifested by the engagement of the earlier mentioned coping strategies of (a) sustaining hope, (b) finding benefits in the experience of CID, (c) searching and making meaning and purpose in one’s life following the onset of CID, (d) sustaining self-efficacy beliefs, and, in general (e) experiencing post-CID growth has documented that positively valenced postimpact coping is uniquely meritorious in overcoming past losses and seeking to achieve a positive and satisfying
level of future QOL (e.g., Carver et al., 1994; deRoon-Cassini et al., 2009; Dunn, 1996; Kortte et al., 2010; Schou, Ekeberg, Sandvik, Hjermstad, & Ruland, 2005; Smedema et al., 2010). For example, postimpact, future-oriented, positive coping modalities, such as those outlined earlier, have demonstrated their positive influence on improved QOL in a wide range of CIDs including, but not limited to, SCI (Pollard & Kennedy, 2007), traumatic brain injury (Moore, Stambrook, & Gill, 1994), multiple sclerosis (Pakenham, 2005), epilepsy (Amir, Roziner, Knoll, & Neufeld, 1999), heart disease (Garnefski, Kraaij, Schroevers, & Somsen, 2008), cancer (Manne et al., 2004), limb amputation (Oaksford, Frude, & Cuddihy, 2005), and general rehabilitation populations (Kortte et al., 2012). The recognition that positive and future-oriented coping efforts exert a powerful influence on the QOL of people with CID ushers several important implications to the field of rehabilitation. Several of these are addressed in the following paragraphs.

Implications to Rehabilitation Theory

The distinction between a past-oriented, negatively valenced and present- and/or future-oriented, positively valenced approach to postimpact (e.g., CID) coping is also implicitly, even if not always explicitly, portrayed in several of the leading models of psychosocial adaptation to CID. For example, two of the leading models of psychosocial adaptation to CID are those of Devins (Illness Intrusiveness model; Devins, Bezjak, Mah, Loblaw, & Gotowiec, 2006; Devins et al., 1993) and Bishop (Disability Centrality model; Bishop, 2005; Bishop, Stenhoff, & Shepard, 2007). Although both models share a common core of concepts and mechanisms (Bishop, by his own admission, even argues that his model is an extension of Devins's model), and one would be hard-pressed to identify any glaring discrepancies between the two, they nevertheless intimate two distinct philosophical underpinnings that are rooted in discrepant views of human nature and time perspectives. Devins's model is spawned by a traditional medical model that suggests the supremacy of concepts such as psychopathological processes, sickness, passivity, and functional deficits. These notions are clearly evidenced in the use of terms such as intrusiveness of disease, disruption of global lifestyle, burden of illness, and diminished participation in valued life functions. This philosophical framework is also anchored in the model's overarching mostly, but not inclusively, unidimensional outcome measure of adaptation to postimpact CID, that of emotional distress–emotional well-being, as reflected in indicators of QOL such as mood disturbance, depressive symptoms, pessimism, and global psychopathological symptoms (Devins et al., 1993). The Illness Intrusiveness model, therefore, focuses mostly on the impact of past losses on present functioning and the "negative" aspects of the human CID experience, including lack of personal control over positive outcomes (which indicates truncated future possibilities) and perceptions of decreased capacity to influence such life outcomes (again suggesting that future options are limited). In contrast, Bishop's model, despite recognizing some of these aspects, including the initial decrease in perceived personal control and the role played by negative emotions, nevertheless incorporates a more positive, present- and future-oriented, and holistic rehabilitation philosophy. In this model, greater emphasis is placed on the person with CID's ability to maintain satisfaction in, and positive control over, central life domains and reprioritize domain centrality to close existing gaps between present levels of experienced QOL and desired or expected (i.e., future-oriented) QOL (Bishop, 2005). Bishop's positive, future-oriented notions are clearly evidenced by his emphasis on the use of processes that increase perceived control and rearrange domain importance, such as self-management, environmental accommodations, and rehabilitation interventions, all indicating a dynamic approach to changes in centrally important domains. Furthermore, Bishop's model adopts a broader and more inclusive view of the QOL concept, as exemplified in its multidimensional view on various life
domains (e.g., physical health, mental health, work, leisure activities, social relationships, spirituality) and their role in psychosocial adaptation to CID.

**Implications to Rehabilitation Practice**

Unlike their disengagement, mostly past-oriented postimpact coping modalities (e.g., avoidance, escape, denial, wish fulfillment, self- or other-blame), postimpact engagement coping (e.g., problem focusing, planning, positive reframing, active acceptance, seeking social support) and coping resources (e.g., hope, optimism, benefit finding, meaning making) are mostly future-oriented. Disengagement coping efforts are, in general, oriented toward past events. For example, blaming self or others for CID onset focuses on irrevocable past losses and the reasons for their occurrence. Wish fulfillment can be equated with attempts to negate or nullify the reality of CID and avoiding confrontation with a realistic CID-experienced future. In contrast, engagement coping and the use of positive coping resources are, in general, squarely anchored in present experiences and, likewise, view the future more favorably and as realistically changeable (e.g., hope, optimism, planning, seeking social support). Furthermore, whereas the former modalities largely dwell on the sustained losses and functional deficits (e.g., CID) or seek to negate their reality by adopting subterfuge mechanisms, the latter modalities focus on efforts that seek to build on remaining functions and available skills and resources.

Adoption of future-oriented postimpact engagement coping strategies and tapping into available positive coping resources have been, indeed, repeatedly documented to promote higher levels of perceived QOL among a wide range of people with CID (Elfström & Kreuter, 2006; Livneh & Wilson, 2003; McMillen & Cook, 2003; Pakenham, 2006; Sears, Stanton, & Danoff-Burg, 2003). In contrast, when postimpact coping has been limited to past-oriented (or, separately, future-truncated) disengagement coping strategies, the literature has conclusively shown decreased reports of QOL by people with CID, as indicated by higher levels of post-CID depression and anxiety and lower levels of perceived well-being and life satisfaction (e.g., Kemp & Krause, 1999; McCabe, Stokes, & McDonald, 2009; M. K. Wagner, Armstrong, & Laughlin, 1995). Rehabilitation practitioners, therefore, would benefit from promoting client awareness of their available coping resources and use of future-oriented, engagement coping strategies. In addition, discouraging client use of past-oriented, disengagement, loss-dominated coping strategies should be identified and discouraged. Postimpact, future-oriented coping intervention modules that address CID-related psychosocial adaptation have been developed and successfully implemented by Radnitz (2000), Kennedy and colleagues (Kennedy, 2008; Kennedy, Duff, Evans, & Beedie, 2003), and Sharoff (2004). These coping interventions rely, largely, on the use of cognitive restructuring and reframing skills, problem-solving skills, planning for future eventualities, and related cognitive-behavioral interventions, all seeking to bolster engagement coping skills.

Another temporally based clinical intervention that provides fruitful implications to serving individuals who sustained CID can be found in the work of Zimbardo and colleagues (Sword, Sword, Brunskill, & Zimbardo, 2014; Zimbardo & Boyd, 2008). Derived from Zimbardo’s temporal theory (Zimbardo & Boyd, 2008), the authors developed an intervention modality known as *time perspective therapy (TPT)*. In this theoretical and clinical approach, time is perceived as psychological time, that is, a subjective, flexible, and dynamic concept, rather than an objective, rigid, scientifically measured duration of time. In this approach, the rehabilitation professional is concerned with the perception of experienced past and present events (including CID-triggering situations and
currently held beliefs and perceptions), and their impact on future goals and plans, rather than with their actual temporal unfolding.

Among TPT’s essential operating principles are the following: (a) Human time experience or perception can best be compartmentalized into six (originally five) time zones: past positive (focusing on “good experiences”), past negative (focusing on failures and losses), present hedonistic (focusing on pleasurable experiences), present fatalistic (focusing on inability to control life situations), future (focusing on goals and objectives), and (more recently) future transcendental (for a detailed discussion of each zone the reader is referred to Zimbardo & Boyd, 2008); (b) TP is a learned human experience and latently influences most cognitions, decisions, and behaviors; (c) humans develop time zone biases, such that they tend to over- or under-employ certain time zones when they engage in action-based judgments and decisions; (d) overuse of any time zone(s), especially past negative (“getting stuck in the past”), could have dire consequences to one’s psychological well-being; and (e) individuals function best when they develop and implement a balanced and flexible TP, adapted to their current, dynamic, and continuously unfolding life situations (Sword et al., 2014; Zimbardo & Boyd, 2008). The clinical thrust of TPT, therefore, rests on the premise that past-oriented people make decisions and act according to both negative and positive (even if no longer appropriate) memories of similarly encountered situations. Future-oriented individuals, in contrast, reach their decisions and initiate behaviors based on rational assessment of anticipated consequences and probability of success.

In the context of adaptation to CID, TPT can be best implemented through both making the negative past (onset of CID, the functional losses incurred, and the experienced psychological impact) more manageable and extending the perceived timeline further into the future, a zone where the pursuit of positive goals, the use of coping resources such as hope and optimism, and the employment of future-oriented engagement coping skills all serve to balance out the time zone bias of the negative past. To keep this balance intact, the rehabilitation professional seeks to continuously juggle efforts to minimize reliance on the past negative zone (e.g., the use of past-oriented, disengagement-like coping strategies and negative thoughts), leveraging the present (mostly hedonistic) zone to initiate new and realistic life goals and plans, as well as bolstering self-confidence/efficacy, and ultimately ensuring that the positively valenced future time zone gains supremacy in the client’s life (Sword et al., 2014; Zimbardo & Boyd, 2008). Although TPT is a relatively nascent therapeutic intervention, and requires additional supportive documentation of its merits, preliminary documentation of the association between time perception and psychosocial adaptation to CID (i.e., cardiac disease, diabetes) has been reported in the literature (e.g., Hamilton, Kives, Micevski, & Grace, 2003; Livneh & Martz, 2007).

Implications to VR
The field of VR has traditionally focused on helping people with CID seek and secure employment commensurate with their functional level, skills, and abilities. Two pivotal concepts that have undergirded much of the success incurred by VR are those of strengthening client (functional) life skills and motivation level. As viewed from a post-impact, future-oriented, positively valenced coping perspective, both concepts acquire additional meaning that can serve to further elucidate their importance and usefulness. Life skills have been operationalized as skills that include self-direction and determination skills, self-care skills, employment skills, work tolerance skills, and communication skills (Chan, Rubin, Lee, & Pruitt, 2003; da Silva Cardoso, Blalock, Allen, Chan, & Rubin, 2004). These skills, when acquired postimpact, exemplify future-oriented,
engagement-like coping modalities, and have been shown to be positively associated with subjective well-being. Furthermore, VR services geared toward improving these life skills were also found to improve reported QOL (da Silva Cardoso et al., 2004). These findings, demonstrating the benefits accrued by the use of future-oriented vocationally adaptive skills and life-functioning skills within the world of work and their impact on clients’ QOL, have prompted rehabilitation researchers (Rubin, Chan, Bishop, & Miller, 2003; Rubin, Chan, & Thomas, 2003) to maintain that QOL may be a better predictor of long-term rehabilitation success, because life-functioning skills, in general, and employability skills, more specifically, require extended time to be fully internalized and successfully processed. It can, therefore, be argued that when applied to VR services, the careful implementation of programs that focus on future-oriented (both proximal and distal), adaptive life coping skills that seek to comprehensively instill physical (i.e., self-care), psychological (i.e., self-direction and determination), social (i.e., communication), and vocational (i.e., work tolerance, performance of specific job activities) skills is likely to promote higher perceived QOL and, relatedly, long-term vocational success. This assumed link of postimpact engagement coping strategies → functional life skills → improved QOL → successful vocational outcomes certainly merits further exploration and verification.

The importance of the second concept, that of client motivation level, has been well recognized by practitioners in the field of VR for more than half a century, but has experienced a renewed clinical and empirical interest with the advent of the therapeutic approach known as motivational interviewing (MI; Miller & Rollnick, 2002; C. C. Wagner & McMahon, 2004). It is beyond the scope of this chapter to faithfully address the many features and innovations of the MI approach to VR, but its shared elements with postimpact, future-oriented coping skills must be recognized. MI can be best understood as a goal- (i.e., future-) oriented, self-determination- (i.e., adaptive coping-) enhancing, and change-of-life seeking approach to promote client motivation, explore and resolve ambivalence, and ultimately change maladaptive cognitions and behaviors and replace them with adaptive ones (Chou, Ditchman, Pruett, Chan, & Hunter, 2009; Miller & Rollnick, 2002). The MI approach emphasises on empathic listening; seeking, planning, and implementing specific goals (e.g., health-related, vocational); and committing oneself to needed changes is akin to that undertaken by rehabilitation professionals who seek to train their clients in the use of engagement-type, adaptive coping skills that focus on the judicial and proficient use of such coping strategies as using emotional and instrumental support, cognitive reframing, and active planning to enhance successful psychosocial adaptation to CID. Both approaches share a common, overarching mission that focuses on (a) promoting autonomy and responsibility in implementing changes and adaptation to life both pre-CID (e.g., health maintenance, disease prevention; see earlier discussion on PP, and preimpact and preventive coping) or following CID onset (e.g., substance abuse, SCI, cardiovascular disease); (b) relying on decision-making and problem-solving skills to chart one’s therapeutic course while implementing life (e.g., health-oriented, psychosocial, vocational) changes; (c) boosting self-efficacy/confidence during the process of adaptation to CID, including the acquisition of job skills and increasing employment opportunities; and (d) encouraging hope and optimism, both perceived as future-oriented motivational tools and coping resources, when seeking behavioral changes, psychosocial adaptation, and successful employment (Chou et al., 2009; C. C. Wagner & McMahon, 2004). Bolstering client motivation and enhancing future-oriented life changes, as envisioned by proponents of the MI approach, are highly commensurate with the future-oriented, engagement coping–type therapeutic framework advocated by psychosocial rehabilitation professionals.
Both approaches have amassed an impressive body of clinical and empirical literature to support their usefulness, although they have followed separate professional routes. It is hoped that by recognizing both approaches’ underlying theoretical and clinical commonalities, rehabilitation professionals from both camps seek to cross-fertilize the bodies of knowledge and strengths inherent in both approaches, thus benefitting the rehabilitation field as a whole.

**Implications to Rehabilitation Research**

As was observed earlier in this chapter, although postimpact coping strategies emanate from past traumatic events (e.g., injuries, life-threatening diagnoses), they are by no means exclusively past-oriented and, in fact, often focus on presently encountered obstacles and barriers, as well as anticipated future issues. Indeed, it is the latter coping orientation that has been often associated with successful psychosocial adaptation, better QOL, and positive rehabilitation outcomes. One area that the rehabilitation researchers may wish to address, and further clarify, is the nature of the relationships between these coping strategies and psychosocial adaptation. For example, do these strategies directly influence perceived QOL (e.g., life satisfaction, well-being) and other, more objective indicators of QOL (e.g., community integration, occupational success) among people with CID, or are these relationships further mediated or moderated by (a) specific psychological mechanisms such as cognitive processes, appraisal, (control) belief system, motivational level, flexibility, and range of coping modes; (b) various situational determinants; and (c) degree, duration, or severity of the stress itself (Folkman & Lazarus, 1988; Folkman & Moskowitz, 2004; Mattlin, Wethington, & Kessler, 1990; Moos & Holahan, 2003; Terry, 1994). Furthermore, it would be of interest to learn what mechanisms and post-CID experiences may exist that differentiate between these successful future-oriented coping strategies and those that are past-oriented and typically associated with poorer adaptation.

Another fruitful area for research efforts includes the study of how the use, nature, and dynamics of these post-CID future-oriented (e.g., proactive, anticipatory) coping strategies differ from future-oriented coping in the absence of CID, that is, coping strategies that are not triggered by traumatic onset but rather by mere anticipation and wish to prevent future events (the more traditional future-oriented coping). Researchers may also wish to consider another potential venue that focuses on investigating whether the scope, frequency, and clinical efficacy of post-CID coping strategies differ according to such CID-related characteristics as nature of onset (e.g., gradual, sudden), time of onset, duration of condition, severity of the CID, its course (e.g., stable vs. variable; predictable vs. unpredictable), and so on.

Finally, in certain situations, it is expected that both preemptive (e.g., anticipatory) and post-CID coping occur. These situations involve medical procedures such as planned surgery (e.g., limb amputation, mastectomy, open heart surgery) and side effects of administered medication (e.g., chemotherapy, radiation therapy) among others. Research could shed light on such intriguing questions as what transitions in coping strategies, from preevent to postevent, predict better psychosocial adaptation and reported QOL. When put differently, is there an “ideal” or beneficial coping transition (e.g., a particular pattern of preevent to postevent set of coping strategies) that can predict better psychosocial adaptation, as indicated by such outcome measures as assessed QOL, perceived well-being and life satisfaction, level of depression and anxiety, and even nonpsychological outcomes such as level of experienced pain, degree of functional abilities, extent of social pursuits, and community integration.
Note

1. Most crisis researchers and clinicians maintain that the typical duration of crisis ranges from 4 to 8 weeks (e.g., Janosik, 1984; Roberts, 2000; Slaikeu, 1990), but also differentiate between equilibrium restoration that is time-limited and crisis resolution that is of longer duration and necessitates the development and implementation of new and adaptive coping strategies.

REFERENCES


Inequality is perhaps America’s most egregious, embarrassing, and least desirable trait as an industrialized nation. Although some would argue the United States ideally upholds egalitarian values and traditions, its history chronicles a plethora of contradictions dating back to the country’s formation (David, 2014; Fox & Marini, 2012; Hughes & Avoke, 2010; Liu, 2011; Ramsey & Marini, 2016; Smiley & West, 2012; Stiglitz, 2013). If Gandhi, Churchill, Hubert Humphrey, Pope John Paul II, Dostoyevsky, and others’ observations that a society is judged by how it treats its most vulnerable members (paraphrased) is accurate, then the United States has surely failed. Indeed, with the greed and corruption of corporate America embedded and arguably controlling the political system with financial contributions supporting their causes, there is no voice to advocate for its poor and most in need citizens (Huffington, 2003, 2010; Marini & Stebnicki, 2012; Ramsey & Marini, 2016; Smiley & West, 2012; Stiglitz, 2013; Warren, 2014).

The root causes of social injustice are in part centralized around wealth inequalities, politicians, and legislation favoring the wealthy, discrimination, and a Darwinian mentality (Greenwald, 2011; Marini, 2012b; Warren, 2014). Whereas Darwin and his followers in the late 19th century espoused natural selection in that the strong will survive and the weak shall perish regarding eugenics, Marini (2012b) states the 21st-century mantra has morphed into a more surreptitious “survival of the financially fittest” social psyche (p. 490). The eugenics movement in its extreme during Hitler’s Nazi regime murdered an estimated 300,000 German citizens with disability deemed “undesirables” and “useless eaters.” Survival of the financially fittest in today’s era, however, is much less conspicuous in the overall harm it afflicts on its most vulnerable citizens. When the life expectancy for Americans living in one ZIP code differs by 20+ years compared to those living several miles away in another code due partially to wealth disparities, it behooves us as a society to solve such social and moral problems (Bloch, 2013).

In this chapter, we explore the ramifications of social injustice in America focusing on those with disabilities. The ripple effect of poverty, oppression, and disability, and its subsequent deleterious impact for equitable treatment and opportunity, is discussed. Beginning with prevalence statistics regarding poverty in general and disability specifically, the chapter segues into an exploration of the domino and vicious cycle effect of
inequitable education, employment, health care, and health. The resulting psychosocial impact on minorities and those with disabilities is a reciprocal occurrence between these populations interacting with an arguably apathetic societal and political populace. Finally, a dialogue regarding the social justice counselor and strategies for counseling and advocating for this most ignored and disenfranchised population in America is discussed.

POVERTY AND DISABILITY IN AMERICA

Poverty in America has remained relatively unchanged during the past 5 years. In the Current Population Survey (2015), the U.S. Census Bureau indicates that more than 46 million, or 14.8%, of Americans continue to live in poverty. It is interesting to note that poverty rates did edge up between 2013 and 2014 for individuals with disabilities, those with bachelor’s degrees or higher, and married couples, indicating even those with a postsecondary education or perhaps two incomes were at risk. As with previous years, approximately one in five children lived in poverty according to federal guidelines. The 2014 U.S. federal poverty rate for single, younger persons under 65 was $11,670. For single parents, the rate was $15,730 with one child; comprised of 30.6% for a female single parent and 15.7% for a single male parent. For two-parent households with two children, the poverty rate was $23,850 per year. As in previous years, minorities had significantly higher poverty rates. African Americans led the way at 27.4%, Hispanic/Latinos at 26.6%, Asian Americans at 12.1%, and Caucasians at 9.9% (U.S. Department of Health and Human Services, 2014).

For persons with disabilities in 2014, the poverty rate differed depending on one’s age. For children younger than 5 years, 34% of their primary caregivers surveyed lived in poverty (Annual Disability Statistics Compendium, 2014). This rate dropped to 32.6% between ages 5 and 17 years, and lowered further to 28.2% for those between 18 and 64 years of age. For the same adult age group of persons without disabilities, the comparative rate was only 13%; therefore, the rate for those with disabilities living in poverty was more than double that for those without disabilities with the same demographics. A similar near doubling trend was also observed between those with and without disabilities at the other age groups as well. The prevalence with which persons with disabilities require some type of assistance gradually increases with age; roughly less than 10% at age less than 15 years and more than 50% at age 80 years or older (Brault, 2012).

When combining disability and minority status, persons with disabilities who are a minority are by far the largest population living in poverty, and especially so for disabled female minority parents (Brault, 2012; Hughes & Avoke, 2010). Greater than one in four children with disabilities live below the poverty level, with the greatest prevalence being single female minority families (Parish, Rose, & Andrews, 2010). Smiley and West (2012) cite the vicious cycle of poverty begetting poverty, and the difficulty that impoverished individuals have climbing out of the cycle of poverty. Fremstad (2009) argues that although the poverty and disability literature overlap significantly, they are rarely jointly discussed or connected. He cites that not only are persons of minority with disabilities more likely to be unemployed or surviving off government benefits, but they are also more likely to incur medical costs not otherwise covered by Medicare or Medicaid. The connection among disability, minority status, poverty, and oppression is further detailed subsequently.
The cost of inequitable treatment of persons with disabilities and/or minorities is deleterious not only to these populations, but society as well both socially and economically. During any election cycle, Medicare, Medicaid, and Social Security are always topics of discussion, generally with politicians acknowledging the increased costs, but few willing to take any steps to actively address solutions. Brault (2012) noted approximately 59% of working age adults with severe disabilities receive some form of public assistance in terms of Social Security, subsidized housing, food stamps, and cash assistance. Approximately 20% receive Supplemental Security Income (SSI), which is the Social Security Administration’s income assistance for persons with disabilities who qualify as being poor. Ouellette, Burstein, Long, and Beecroft (2004) further note that simply citing poverty rates does not fully capture the material hardship that individuals endure. The nuances of living in poverty include housing instability, food insufficiency, living in unsafe neighborhoods, the ongoing stress of potential utility and telephone disconnection, and inadequate or no health care.

Nam, Huang, Heflin, and Sherraden (2012) note the racial and ethnic disparities in America regarding food insufficiency. They and others cite that approximately 17.2 million families in the United States suffer long-term effects of not having enough food and the uncertainty of being able to feed one’s family on a daily basis. This, in turn, has a negative effect on children’s physical and cognitive development and ability to fight chronic diseases, impairs academic achievement, contributes to higher dropout rates, and hurts one’s potential for competitive employment in adulthood (Jyoti, Frongillo, & Jones, 2005; Whitaker, Phillips, & Orzol, 2006). The overrepresentation of minorities with disabilities generationally living in a cycle of continued poverty is alarmingly high and contributes to the large life expectancy discrepancy noted earlier between the haves and have-nots in America (Stiglitz, 2013).

The social cost to persons and/or minorities with disabilities is that they become “stuck” in a continuing ill-conceived poverty cycle, which does not allow SSI recipients to be competitively employed and keep their medical coverage (Marini & Reid, 2001; Marini & Stebnicki, 1999). In addition, the social cost to one’s self-concept and self-esteem is diminished by not being a contributing member to society (Marini, 2012a). The American work ethic has long since been idealized as a primary pathway from rags to riches, and simplistically thought by many to be easily determined by one’s drive, perseverance, and motivation to succeed. Although there are social programs that facilitate these efforts (Ticket to Work), there are also government policies (Medicare work restrictions) that fiscally inhibit efforts of those with disabilities from entering the workforce (Marini & Reid, 2001; Marini & Stebnicki, 1999).

In addition to the self-esteem costs to unemployed individuals who otherwise would like to work is the ever-continuing shaming and negative societal attitudes toward those who are perceived as living off the system (Rose & Baumgartner, 2013). Rose and Baumgartner (2013) studied what we today term public shaming regarding media coverage of almost 50 years regarding poverty in the United States. Specifically, the authors cite numerous media outlets (newspapers, magazines, books, etc.) as well as politicians who frame topics that sway public opinion. They note that framing of the poor in the 1960s was projected as the poor being victims of living in an unfair economic system with poor health options, attending underfunded dysfunctional schools, and subject to racial discrimination. The result of such attitudes and media framing culminated in the
War on Poverty, and the government response to eradicate poverty was immediate and effective, reducing the poverty level from 22% to 12% within 15 years as social program assistance increased from 3% to 8%.

In the early 1970s, however, the discourse on poverty began to change, largely when Ronald Reagan was campaigning for president. Politicians and the media began framing persons living in poverty as lazy, cheaters, and welfare queens having children who were also living off the system (Hancock, 2004; Rose & Baumgartner, 2013). Much like disability, concepts related to the poor are socially constructed and subsequently can shape public policy. Hancock (2004) believed this new discourse largely impacted President Clinton's 1990s Welfare Reform, which saw funding cuts and 5-year maximums for persons on welfare. This sentiment continues to exist today, especially among so many in the Republican Party, as Mitt Romney demonstrated in a 2012 Florida speech to wealthy donors, citing about 47% of Americans who live off the system. During the same 2012 campaign, House Speaker Newt Gingrich’s famous sound bite that President Obama would be “the best food stamp President in American history” also demonstrated the disdain toward the poor and those in government who are perceived as enablers of free taxpayer giveaways to the poor. Although many see the issue of poverty as a rather simplistic dichotomous personal choice of being lazy or alternatively motivated to work, we next turn to how this topic is much more complex when considering the impact of social injustice and oppression in America.

**Education**

Researchers of social economics who focus on the economic complexities of social policies and their impact begin to unravel the stark differences between the haves and have-nots, and the impact of oppression and inequalities, from an early age (Hughes & Avoke, 2010; Liu, 2011; Stiglitz, 2013). These and other authors argue there is a ripple effect for families living in poverty. Poor families typically live in low-income neighborhoods with low property tax revenues to adequately finance local public schools. Hughes and Avoke (2010) note that poorly funded schools may be dilapidated, have poor heating, are underfunded and understaffed, have lower teacher expectations, and statistically experience higher dropout rates. These schools are predominantly in low-income minority neighborhoods, and Balfanz and Legters (2004) cite a 50% dropout rate among African American students and a 40% dropout rate among Hispanics from such neighborhoods.

For students with disabilities, the statistics are equally grim. A U.S. Department of Education (2009) report found that minority students with severe disabilities were more likely to be placed in special education and segregated from the general education population. The curriculum in special education ideally is supposed to focus on developing self-determination and essential job skills needed for employment; however, the special education curriculum often falls far short of curricular expectations (Wehman & Kregel, 1997). Without the opportunity for a quality education or to learn entry-level job skills for the competitive labor market, students with disabilities from underfunded low-income neighborhoods essentially have no skills to become employed. Newman, Wagner, Cameto, and Knokey (2009) found that post-high school, youth diagnosed with a developmental disability had only a 31% mostly part-time employment rate, 14% lived independently or semi-independently, 26% had a checking account, and 7% attended some postsecondary education. Newman et al. concluded that disability and poverty combine for poorer educational opportunities, lower graduation rates, higher dropout rates exceeding 50%, and ultimately poor employment options and rates among youth with disabilities, particularly those of minority status.
Overall, there are statistically poorer economic and employment outcomes for children with disabilities living in low-income neighborhoods who attend underfunded schools when compared to nondisabled children in better funded schools. The dropout, graduation, and ultimately employment rates are drastically different for low-income children with disabilities, and their opportunity to climb out of poverty is marginal at best. Attempting to learn while one is hungry or cold due to insufficient school heating becomes difficult, as is the ability to concentrate on one’s studies when living in low-income, unsafe neighborhoods.

**Employment**

The ripple effect of a poor or inadequate education for the variety of reasons noted previously ultimately impacts one’s ability for competitive employment. Braddock and Parish (2001) cite an 80% unemployment rate among adults with disabilities raised in poverty conditions in the United States. Being a minority female with a disability ranks highest among those most unemployed. Brault (2012) indicates that employment opportunities for persons with disabilities who have not been afforded a quality education and an opportunity to obtain a postsecondary education are relegated to largely entry-level minimum wage occupations performing primarily physical labor. This is not the case for those with mobility impairments, but rather those with cognitive or developmental disabilities if they are capable of performing competitive employment. For those with mobility but no cognitive impairments, there continues to be an approximate 70% unemployment rate overall for this group as well.

One of the major disincentives Marini and Reid (2001) have previously argued, however, is that in the majority of states where the minimum wage remains $7.25 per hour or just more than $15,000 per year (without deducting income tax), combined with the likelihood of losing one’s medical benefits, it is simply not worth the risk for those collecting disability benefits for a minimum wage job. For those single individuals collecting SSI benefits, their maximum earnings are $733 per month. As such, for most individuals collecting SSI amounting to $8,800 per year with medical benefits and given the choice to earn a few thousand dollars more working 40 hours per week with minimal if any medical benefits, it is simply not worth taking the risk. Of all beneficiaries historically on the Social Security roles, less than 1% ever leave to return to the workforce (Marini, 2012a). This same Catch-22 exists for persons with physical impairments who require home care assistance to complete activities of daily living (ADL). All states have maximum daily limits regarding the number of hours per week of home care assistance; however, one must be homebound and services are not provided for those who want/can work and/or drive. Although the archaic Medicare homebound rules allow for an individual to attend adult day care, they are not allowed to work to qualify for activities of daily living (ADL) home care services. The incentive should be to support employment efforts by providing such assistance rather than penalizing those with disabilities who want to work but need home care assistance to do so.

**Health Care and Health Costs**

Individuals without health insurance decreased from 2013 to 2014 largely due to the Affordable Care Act and the mandate for insurance companies to provide coverage for those with preexisting conditions. There was an approximate 23% decrease of uninsured Americans from 41.8 million people in 2013 down to 33 million in 2014 (Current Population Survey, 2015). In her book, *Money Driven Medicine*, Mahar (2006) cites health care practices and costs that demonstrate approximately seven of 10 personal bankruptcies filed by Americans are due to extraordinary medical bills that most hospitals are...
elusive at attempting to explain. Several days of hospitalization for relatively minor surgery can easily exceed more than $100,000, and for the majority of Americans poor or otherwise without adequate insurance, these costs can never be paid. An estimated 15% of private hospitals have also been known to practice “patient dumping” whereby high-cost patients who have been stabilized but do not have insurance are literally dumped off at the door of another hospital or elsewhere (Rice & Jones, 1991). The authors note that the uninsured are made up largely of minorities who generally do not seek medical services until it is an emergency.

As noted earlier, the overall significance of social injustice toward poor minorities with disabilities can result in more than a 20-year difference in life expectancy between this population and those with greater wealth. Although living a long and healthy life is partially an individual’s responsibility, statistics cannot ignore the higher mortality rates among poor minorities who have a disability living in lower income housing, obtaining poorer health care, having an insufficient income to eat healthy, and living in unsafe or hazardous environments and neighborhoods. A two-tier system of inequitable treatment in health care, housing, employment, and education between the have-nots and have-nots ultimately ends with higher and younger mortality rates for the have-nots (Brault, 2012; Liu, 2011; Mahar, 2006; Smiley & West, 2012; Stiglitz, 2013).

**Environmental Inequities**

Persons with disabilities and other minorities have been subtly subjected to social injustices via environmental and social barriers as well. Again, these inequities are related to low socioeconomic status where statistically a majority of minorities and those with disabilities reside. These populations are more likely to live in unsafe neighborhoods without a nearby grocery store or park for recreation and exercise (Liu, 2011). The stark diversity in urban planning between wealthy and poor neighborhoods creates an unhealthy environment for those living in poverty. Individuals living in low-income neighborhoods without a vehicle must travel many miles to a local grocery store, and have difficulty purchasing healthy foods. As such, these neighborhoods typically have convenience stores stocked with high calorie, high sugar, inexpensive foods that are more affordable and available. Obesity and the multitude of secondary health-related complications (e.g., diabetes, hypertension, cardiovascular disease) from being obese are much more prevalent among those living in poverty and in impoverished neighborhoods (Ramsey & Marini, 2016; Romero & Marini, 2012).

Those living in low-income housing also face other environmental hazards. Johnston, Werder, and Sebastian (2016) cite the decades-old common practice of environmental injustice, whereby environmentally hazardous industries take up residence in low-income, mostly minority areas. The authors cite a disproportionately higher number of waste disposal facilities across the country, including oil and gas wastewater disposal wells. The recent publicity of contaminated water wells and the deleterious health impact on the cognitive and physical development of children and adults is appalling. Similarly, although the poisonous health impact (e.g., seizures, mental retardation, nervous system abnormalities) of lead paint have been known for more than 75 years, corporate lead paint proponents successfully lobbied to keep using it, particularly in low-income housing developments, up until the late 1970s (Ludden, 2016).

Lynch and Stretesky (2012) also discuss the environmental injustices imposed on Native Americans and the environmental hazards to which they have been exposed. The authors describe the poverty and income disparities between Native Americans living on the reserve in comparison to non-Native Americans. They cite poverty rates of 37% on nongaming reservations and 27% on gaming reservations. Educational achievement
is also much lower with only 11% holding college degrees on nongaming reserves and 16% on gaming reserves. Housing conditions for many American Indians on non-gaming reserves are also dismal, with a reported 24% of houses lacking indoor plumbing and 26% lacking a complete kitchen. There is no adequate health care coverage on the reserves, leaving families often having to travel great distances to a public hospital. Native Americans have a much higher than average risk for advanced cancer, cardiovascular disease, substance abuse, and suicide. Like other minorities, they too have been exposed to hazardous waste sites from commercial and military toxic waste facilities being built around the communities where they reside.

For persons with disabilities, environmental barriers continue despite the now 27-year-old Americans with Disabilities Act (ADA) of 1990. Recent studies of Americans with disabilities continue to express their daily frustrations with pockets of noncompliance across the country in the areas of transportation, public accommodations, employment protections, and health care access (Graf, Marini, & Blankenship, 2009; Marini, Bhakta, & Graf, 2009). From medical facilities having inaccessible exam tables for wheelchair users, to hospitals and/or medical clinics not offering translators for persons who are deaf, these entities continue to be in violation of the law. ADA filings under the Equal Employment Opportunity Commission (just Title I) since 1997 to 2015 have ranged and gradually climbed from approximately 15,000 to almost 27,000 complaints annually regarding alleged employment discrimination alone (U.S. Equal Employment Opportunity Commission, n.d.). Public accommodations complaints have exceeded these numbers. For most entities that have not made the appropriate ADA changes by now, many of them have taken an apathetic “so sue me” type attitude.

THE PSYCHOSOCIAL COST OF OPPRESSION

David (2014) in his edited book *Internalized Oppression: The Psychology of Marginalized Groups* notes the impact of oppression on persons of minority status and those with disabilities. David and associates note how after years of discrimination and microaggressions, many marginalized individuals succumb to feeling, and ultimately believe, they are devalued or second class citizens. Wright (1988) similarly addressed this concept of succumbing. Ramsey and Marini (2016) also address the psychosocial impact of being devalued and dehumanized by negative societal attitudes. Dohrenwend (2000) found a correlation between perceived discrimination and higher levels of depression and anxiety among minority groups. David (2014) similarly found that individuals who internalized oppression also experienced stress, depression, and anxiety.

Aside from feelings of low self-worth, persons with disabilities who perceive they are discriminated against also report to be less likely to socialize with friends and family, less likely to go to the movies or a restaurant, and more likely to perceive their lives will become worse rather than better (National Organization on Disability, 2004, 2010). Many persons with disabilities living under the poverty level worry about their health and well-being, finances, limited community support, and unsafe or unhealthy living conditions (Cooper, Korman, O’Hara, & Zovistoski, 2009). Besides such daily worries for those minorities with few resources, persons with disabilities continue to experience daily hassles and frustrations dealing with inaccessible businesses, fragmented medical services, and the perceived negative attitudes of others (Graf et al., 2009; Li & Moore, 1998; Marini et al., 2009).

In further exploring the mental and physical health implications for individuals who are, or perceive to be, oppressed and/or discriminated against, a number of interesting studies show the significance of the person–environment interaction and its implications. Aguinaldo (2008), for example, studied the concept of gay oppression as
a determinant of gay men’s health, citing the premise, “homophobia is killing us.” In his literature review, Aguinaldo notes the mental and physical health problems of gay men living in a society that oppresses, discriminates, and is blatantly prejudiced toward them. The resulting fear, physical and verbal abuse, felt hatred, and anger gay males often endure by others carries a heavy psychological toll, sometimes resulting in depression, anxiety, lacking self-worth, shame, self-destructive behaviors such as suicide, inferiority, and self-defeating behaviors (Dempsey, 1994).

Generalized stress and stress-related illnesses have also been linked to others who are oppressed and feel discriminated against (Turner & Avison, 2003). Turner and Avison found that African Americans reported higher occurrences of discriminatory experiences including violence, death, and daily discrimination resulting in chronic stressors when compared with White study participants. Perlow, Danoff-Burg, Swenson, and Pulgiano (2004) noted how discrimination negatively impacts one’s sense of control, and feelings of hopelessness can ultimately lead to a variety of mental health disorders.

If societal discrimination and oppression simply stopped there, the negative physical and mental health impact of oppressed individuals would be alarming in and of itself. Unfortunately, the peripheral implication of perceived prejudice toward an individual or group has further negative ramifications that can exacerbate health problems (Kessler et al., 2003; Krieger, 1999). Numerous studies show the resulting ripple effect of discrimination, including unemployment or underemployment, lower socioeconomic status, poorer health care, lower educational attainment, and poverty (Eaton & Muntaner, 1999; Kessler et al., 2003; Krieger, 1999; Ramsey & Marini, 2016; Williams, Yan, Yu, Jackson, & Anderson, 1997).

Hughes and Avoke (2010) describe the elephant in the room in relation to poverty, disability, and unemployment or underemployment of persons with disabilities. They note that individuals who live under these circumstances are chronically exposed to inadequate housing opportunities, educational opportunities, transportation, poor finances, and concerns about their health or well-being. Current public policies have failed to remedy many of these ongoing problems despite decades-old fair housing legislation, the Individuals with Disabilities Education Act, and the ADA. Much like the 1964 Civil Rights Act has taken decades to gradually remedy the impact of oppression and discrimination, the full equal rights of minorities and those with disabilities have yet to be reconciled and continue to be violated to this day. Marini (2012b) poses the question as to whether the glass is half-full or half-empty concerning the human rights of persons with disabilities.

In measuring the pulse of American politics regarding disability equal rights, the ADA in all probability will remain in effect for the foreseeable future to be the last major effort to better the lives of persons with disabilities. In the 2016 presidential race, for example, neither party campaigned on any further improvements to or strengthening of the civil rights of persons with disabilities. Even with such promises, the gaps in the law and the lack of legal oversight to enforce the law leave much of it relatively ignored across parts of the country, and left up to individual citizens with disabilities to police their own law and file suits.

**SOCIAL JUSTICE**

The American Counseling Association (ACA) has led the way only recently in considering social justice to be a valid counseling specialization. Specifically, in its 2014 revised code of ethics, ACA cites "when appropriate, counselors advocate at the individual,
group, institutional, and societal levels to examine potential barriers and obstacles that inhibit access and/or growth and development of clients” (ACA, 2014, p. 5). The ACA has also approved the new Division for Counselors for Social Justice within the ACA. On its 2010 homepage defining what social justice counseling entails, the Division for Counselors for Social Justice cites:

Social justice counseling represents a multifaceted approach to counseling in which practitioners strive to simultaneously promote human development and the common good through addressing challenges related to both individual and distributive justice. Social justice counseling includes empowerment of the individual as well as active confrontation of injustice and inequality in society as they impact clientele as well as those in their systemic contexts. In doing so, social justice counselors direct attention to the promotion of four critical principles that guide their work; equity, access, participation, and harmony. This work is done with a focus on the cultural, contextual, and individual needs of those served. (Counselors for Social Justice, American Counseling Association, n.d., para. 5)

Greenleaf and Williams (2009) discuss the view that the counseling profession has been largely driven or entrenched by the medical model paradigm, one that focuses exclusively on the individual and treating his or her impairments. This represents a pathological orientation to diagnosis and treatment described earlier, and is perhaps no better evident than our reliance on the Diagnostic and Statistical Manual of Mental Disorders (5th ed., DSM-5, American Psychiatric Association, 2013). However, to truly consider a holistic approach toward working with people with disabilities, we must consider the 81-year-old writings of Lewin (1936) concerning the person–environment interaction discussed in Chapter 5. Specifically, our behavior is a function of our individual traits and characteristics in response to our interactions with our environment ($B = f [P \times E]$). Numerous empirical studies have shown that regardless of how strong a character someone has, with a perceived discriminatory social environment, the individual’s physical and mental health may be negatively affected (Dohrenwend, 2000; Gee, 2002; Li & Moore, 1998; Ramsey & Marini, 2016; Rumbaut, 1994; Williams & Williams-Morris, 2000).

The Social Justice Counselor

The paradigm shift in how we work with clients must extend beyond simply working with them and their families, to ultimately exploring what, if any, societal and environmental barriers may likely block their goals (Neville & Mobley, 2001). It has been suggested that social advocacy is the “fifth force” within the counseling profession, essentially an extension and complement to the multicultural movement (Ratts, D’Andrea, & Arredondo, 2004, p. 28). The ecological approach to counseling acknowledges that an unfriendly environment can have on the well-being of clients (Wilson, 2003). Ivey and Ivey (1998) describe the Developmental Counseling and Therapy model, noting how external stressors can impact intrapsychic changes in clients. The authors cite the progression and reciprocal effect of these interactions, including (a) environmental or biological insult, which may lead to; (b) stress and physical/emotional pain, which may lead to; (c) sadness/depression, which may lead to; (d) defense against the pain, possibly mental disorders.

In providing a holistic approach to helping clients with disabilities, counselors must be willing to not only acknowledge social injustice exists but also willing to go the extra mile to do something about it. As the Division for Counselors of Social Justice web page indicates, “Social justice counseling includes empowerment of the individual as well as active confrontation of injustice and inequality in society as they impact clientele
as well as those in their systemic contexts.” In defining exactly what “active confrontation of injustice and a quality in society” means, counselors must be aware of what their job’s contractual limitations are, if any, regarding Congressional letter writing, advocacy, peaceful protests, and other legal remedies to confront injustice and inequality. The ACA has been quite effective over the years in rallying its 43,000 plus constituents by providing them with legislative alerts, synopsis of relevant legislative bills being introduced for passage, who their congressional leaders are, and sample letters for counselors to use as a template. The ACA Advocacy Competencies (Lewis, Arnold, House, & Toporek, 2003) concerning social justice advocacy in counseling recognizes the ecological model; oppression and discrimination are socially constructed and have a damaging physical and mental health impact on individuals who are functioning within a toxic reciprocal person–environment atmosphere (Bronfenbrenner, 1977; Wilson, 2003).

Several recent school counselor education publications have addressed active steps in preparing counselors for social justice (Bemak & Chung, 2008; Steele, 2008). Bemak and Chung (2008), for example, describe ACA advocacy competencies in relation to promoting systems advocacy, student empowerment, identifying specific advocacy strategies to communicate to colleagues, and stressing the need to further disseminate information to other constituents. These competencies emphasize strength in numbers and group action in promoting equality in educational funding, adequate resources, and a safe learning environment. To passively sit back and counsel students in a dysfunctional or antiquated learning environment is inadequate. The authors cite potential counselor concerns as to why they may not want to become involved in remedying social injustice problems. Some obstacles include general apathy, being labeled as a troublemaker, fear of retribution, a sense of powerlessness, and anxiety that can lead to guilt for not advocating. Bemak and Chung offer recommendations to assist counselors; for example, aligning social justice advocacy with organizational mission and goals, using data-driven strategies, having the courage to speak out, taking calculated risks, recruiting colleagues and others in the cause, developing political partners, becoming politically knowledgeable, and keeping faith (Bemak & Chung, 2008, pp. 379–380).

In considering social justice regarding persons with disabilities, counselors and case managers can influence a number of possible inequities in health care, education, housing, and employment. Persons with disabilities and especially those of minority status are statistically the most disenfranchised population in the United States (National Organization on Disability, 2004). Counselors have to acknowledge environmental inequities as well as the implications that oppression and discrimination can have on clients who can succumb to and give up trying (Dempsey, 1994; Dohrenwend, 2000; Gee, 2002). Thesen (2005) discusses how he and other physicians often knowingly or unknowingly treat patients in a dehumanizing and oppressive manner. He indicates that this type of behavior is counterproductive to patient health and can leave them feeling powerless and without any control. Thesen calls for medical professionals to instead empower their patients by including them in the decision-making process, educating them, and acknowledging their concerns. Bham and Forchuk (2008) illustrated empirically Thesen’s (2005) premise in their interview of 336 current and former psychiatric and/or physically disabled clients. Specifically, the authors found that patients with comorbid conditions of a psychiatric and physical disability perceived themselves to be more discriminated against and oppressed by health care professionals. This, in turn, positively correlated with psychiatric problem severity, self-rated general health, and poorer life satisfaction and well-being. Counselors should be prepared to step in and advocate for clients when they witness the negative attitudes of health care professionals.
In other life domains concerning clients with disabilities, counselors and case managers should be prepared to tackle social injustice issues that impede client progress in the social and vocational realm. Despite the 20-year-old ADA, environmental barriers still exist that have been shown to result in some persons with disabilities feeling frustrated, angry, socially anxious, and depressed at times (Charmaz, 1995; Di Tomasso & Spinner, 1997; Graf et al., 2009; Hopps, Pepin, Arseneau, Frechette, & Begin, 2001; Li & Moore, 1998; Marini et al., 2009). Counselors can assist clients in constructing letters to business owners demanding removal of access barriers, filing complaints with the Office of Civil Rights, referring clients to Client Assistance Programs (CAPs), and finding an ADA lawyer if necessary (Blackwell, Marini, & Chacon, 2001; Blankenship, 2005; Marini et al., 2009). There appears to be little doubt from numerous empirical studies showing negative or perceived hostile environmental conditions can, and do, have a negative impact on client well-being. For counselors to concern themselves just with assisting clients to deal with living in an able-bodied world, it is a job that is left unfinished or incomplete.

**ADVOCACY**

Social justice and advocacy are sometimes used interchangeably and are often considered synonymous concepts. The primary difference, however, is that social justice is a broader concept recognizing unequal power, unearned privilege, and oppression (Alston et al., 2006). Advocacy is more behavioral and action oriented, and is an activity that often involves actions to correct some social injustice. As such, several authors discuss social justice advocacy in relation to some perceived social inequity. O’Day and Goldstein (2005) interviewed 16 disability advocacy and research leaders regarding the top contemporary advocacy issues concerning persons with disabilities. Disability advocacy organizations, such as the Consortium of Citizens with Disabilities (CCD), Not Dead Yet (NDY), Americans with Disabilities for Attendant Programs Today (ADAPT), American Association of People with Disabilities (AAPD), and others, are involved with grassroots advocacy, ongoing events, rallies, and information dissemination regarding important legislative issues toward enhancing full inclusion of persons with disabilities. O’Day and Goldstein found the top 5 contemporary issues were affordable and accessible health care, employment, access to assistive technology, long-term care, and civil rights enforcement concerning Titles II and III (public services and public accommodations) of the ADA. Similar concerns have been reported elsewhere (Graf et al., 2009; Marini et al., 2009).

Advocacy can take several forms in terms of action. The simplest form of advocacy involves letter writing to local and state constituents in attempts to bring attention to some social inequity, such as accessible housing. Arguably, more extreme forms can involve peaceful protests, such as occupying lawmakers’ offices and sometimes subsequent citations for trespassing. The group ADAPT has been relentless and fairly successful over the past several decades in promoting disability rights, with its successful start in the early 1980s fighting for public accessible transportation in major cities, including city buses, subways, and Greyhound bus lines. The group would organize; primarily the wheelchair users would block buses, chain themselves, and otherwise occupy legislators’ offices to be heard. In time, the majority of their efforts were successful in bringing major change across America, where persons with physical disabilities were unable to use public transportation. During the past decade or so, ADAPT has focused its fight on community-based care, whereby persons who require assistance with activities of daily living are not confined to institutional settings.

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living do not have to live in a nursing home. Their motto is “free our people,” arguing that more than two thirds of federal and state monies are successfully lobbied into nursing homes instead of the money following the person who chooses to live at home. For counselors and case managers who work for the state or federal government, the central question becomes whether this type of advocacy to support such causes has any job repercussions. If conducted on our own time, there generally is no adverse impact; however, counselors are encouraged to be familiar with their agency’s workplace policies. Too often when we advocate, we do so for our own interests and to protect our jobs or territory and disguise it as client beneficence.

Ericksen (1997) indicates that advocacy is conceptually a cross between public policy, public relations, and conflict resolution. Lee (1998) defines advocacy as becoming the voice of the clients and taking action to make environmental changes that may impede barriers to a client’s career, academic, personal, or social goals. Semivan and White (2006) noted that the skills needed for effective advocacy include passion, fact-finding, knowledge, data-based research, and goal-oriented concrete objectives. They must also know the limits of their professional roles and be able to separate highly charged emotions from their actions. Stewart, Gibson-Semivan, and Schwartz (2009) cited practical advocacy strategies to include (a) identifying the target population and the nature/facts of the injustice; (b) developing a rationale as to how advocacy will affect the advocate and target population chosen; (c) developing clearly and concisely how advocating will fit the therapist’s role, and fits within the scope of practice or ethics for the counselor; (d) conducting research on the background and nature of the social injustice thoroughly, including speaking to individuals who have been affected by it; (e) developing a list of references and resources for dissemination; (f) outlining the broader and then individual measurable goals of the advocacy project and reviewing them regularly for refining if necessary; and (g) after selecting goals, determining what the first steps are and whose responsibility it is to carry out each activity (Stewart et al., 2009).

So how can rehabilitation educators, researchers, and counselors either directly or indirectly become better advocates for persons with disabilities? For educators, teaching students about relevant advocacy community services, such as CAPs, legal aid, guardianship, and services provided by Centers for Independent Living (CILs), becomes important in knowing about nonmedical services that can help in social injustice situations (Blankenship, 2005; Marini et al., 2009). In addition, educators can teach students about legislation pertaining to persons with disabilities, provide legislative alerts, and show students how to write to legislators on behalf of persons with disabilities. Two organizations that are extremely effective in providing information and education on these topics are the National Rehabilitation Association and the ACA. Educators can also have letter-writing campaigns for important legislation as part of a class grade, and/or attend or develop local information sessions about impending legislation. Overall, teaching students how to advocate effectively can then be passed on to teaching clients with disabilities once students graduate.

For rehabilitation education researchers, studying the impact of teaching and empowering persons with disabilities about how to advocate for themselves can minimize years of dependency on others who have traditionally made decisions for them (Brinckerhoff, 1994). Brinckerhoff noted how teaching adolescents affected by learning disability self-advocacy skills regarding effectively managing their college experience can be self-empowering and enhance self-esteem (Van Reusen & Bos, 1990). Research topics could include a control and experimental group design, provide the experimental group with tangible training skills to become more proficient
at some self-advocacy task, and then measure the psychosocial impact of empowerment, locus of control, and self-efficacy. Anecdotally, it would seem self-evident that individuals who are taught skills to become more proficient in mastering or controlling parts of their environment would enhance client self-esteem and self-confidence.

Counselors working directly with persons with disabilities in a variety of settings and in a variety of ways can work with clients directly regarding advocacy and self-empowerment issues. Although many counselors have been empowering clients for years regarding job clubs, job search strategies, interview skills training, and so on, others may tend to “do for” rather than “do with” clients, which can be counterproductive. Brodwin, Star, and Cardoso (2007), for example, discuss the importance of including clients in selecting assistive technology or adaptive equipment, because without client input, many clients will not use or will discard the device. As noted with educators, counselors can refer clients to appropriate advocacy agencies, assist in writing letters of complaint or letters to congressional leaders, and teach assertiveness and advocacy skills in presenting their case.

CONCLUSIONS

In many ways, rehabilitation and other counselors have become somewhat desensitized to the unchanging 70% plus unemployment and underemployment rate among persons with disabilities (Houtenville, 2000, National Organization on Disability [NOD], 2004), alarmingly high dropout rates for students (NOD, 2004), higher poverty rates (Hughes & Avoke, 2010; McNeil, 2001), poorer and inadequate health care (Berk, Schur, & Cantor, 1995), social oppression and discrimination (Ratts et al., 2004), and ongoing physical access barriers for persons with disabilities (Graf et al., 2009; Marini et al., 2009). The Social Justice Counselor is a relatively new breed of counselor who actively advocates for change in the community and among policy makers when part of the client’s issues has an environmental basis. Counselors in training should not only learn about how to assist clients with disabilities with coping skills to live in an able-bodied world but also empower and actively assist clients to combat social injustice and oppression in their lives.

REFERENCES


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