

Psychosocial Adaptation to Chronic Illness and Disability: A Primer for Counselors

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In this article, the authors discuss 3 broad domains of psychosocial adaptation to chronic illness and disability. These include the dynamics (basic concepts, psychosocial responses, and coping strategies) typically associated with the process of adaptation to disabling conditions, assessment of adaptation as evidenced by 6 commonly used measures, and intervention strategies applied to facilitating coping with and adaptation to chronic illness and disability.

Chronic illnesses and disabling conditions are common occurrences in the lives of many individuals. It has been estimated that approximately 54 million Americans (about 1 in 5) have physical, sensory, psychiatric, or cognitive disabilities that interfere with daily living (Bowe, 2000). Furthermore (a) more than 9 million Americans with disabilities are unable to work or attend school; (b) costs of annual income support (e.g., supplemental security income, social security disability insurance) and medical care provided by the U.S. government to assist people with disabilities is about \$60 billion; (c) disabilities are higher among older people, minorities, and lower socioeconomic groups; and (d) 8 of the 10 most common causes of death in the U.S. are associated with chronic illness (Eisenberg, Glueckauf, & Zaretsky, 1999; Stachnik, Stoffelmayr, & Hoppe, 1983).

Many disability- and nondisability-related factors interact to create a profound effect on the lives of individuals with chronic illness and disabilities (CID). Among these, the most commonly recognized factors include the degree of functional limitations, interference with the ability to perform daily activities and life roles, uncertain prognosis, the prolonged course of medical treatment and rehabilitation interventions, the psychosocial stress associated with the incurred trauma or disease process itself, the impact on family and friends, and the sustained financial losses (e.g., reduced income, increased medical bills).

The intent of this article is to provide the reader with an overview of (a) the dynamics (i.e., process) of psychosocial adaptation to CID, (b) methods commonly used to assess psychosocial adaptation to CID, and (c) intervention strategies applied to people with CID.

The Dynamics of Psychosocial Adaptation to CID

The onset of CID is typically associated with a disease process (e.g., multiple sclerosis [MS], cancer) or a traumatic

injury (spinal cord injury, traumatic brain injury). CID is also dichotomized into congenital, or evident at birth (e.g., spina bifida, cerebral palsy), and adventitious, or acquired later in life (Parkinson's disease, amputation). In this article, we focus on psychosocial adaptation to acquired disabling conditions.

This overview of the literature on psychosocial adaptation to CID is grouped under three headings: basic concepts, CID-triggered reactions, and CID-related coping strategies.

Basic Concepts

Included here are the concepts of stress, crisis, loss and grief, body image, self-concept, stigma, uncertainty and unpredictability, and quality of life.

Stress. Individuals with CID normally face an increase in both the frequency and severity of stressful situations (Falvo, 1999; Horowitz, 1986). Increased stress is experienced because of the need to cope with daily threats that include, among others, threats to (a) one's life and well-being; (b) body integrity; (c) independence and autonomy; (d) fulfillment of familial, social, and vocational roles; (e) future goals and plans; and (f) economic stability (Falvo, 1999).

Crisis. The sudden onset of many medical impairments and disabilities (e.g., myocardial infarction, spinal cord injury, traumatic brain injury, amputation) and that of life-threatening diagnoses or loss of valued functions (e.g., cancer, vision impairment) is highly traumatic. As such, these conditions constitute a psychosocial crisis in the life of the affected person (Livneh & Antonak, 1997; Moos & Schaefer, 1984). Although crisis, by definition, is time-limited (e.g., Janosik, 1984), during its presence life is affected by disturbed psychological, behavioral, and social equilibrium. The psychological consequences of crisis are, in contrast, long lasting and may even evolve into pathological conditions such as posttraumatic stress disorder (PTSD).

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Loss and grief. The crisis experienced following the onset of a traumatic or progressive CID triggers a mourning process for the lost body part or function. In a manner parallel to that evidenced following the loss of a loved one, the individual exhibits feelings of grief, bereavement, and despair (Parkes, 1975; B. A. Wright, 1983). The term *chronic sorrow* has often been used to depict the grief experienced by persons with CID (Burke, Hainsworth, Eakes, & Lindgren, 1992; Davis, 1987). Unlike grief associated with non-bodily losses, CID serves as a constant reminder of the permanency of the condition. Furthermore, daily triggering events act to remind the affected person of the permanent disparity between past and present or future situations (e.g., Teel, 1991).

Body image. Body image has parsimoniously been defined as the unconscious mental representation or schema of one's own body (Schilder, 1950). It evolves gradually and reflects interactive forces exerted by sensory (e.g., visual, auditory, kinesthetic), interpersonal (e.g., attitudinal), environmental (e.g., physical conditions) and temporal factors. CID, with its impact on physical appearance, functional capabilities, experience of pain, and social roles, is believed to alter, even distort, one's body image and self-concept (Bramble & Cukr, 1998; Falvo, 1999). Successful psychosocial adaptation to CID is said to reflect the integration of physical and sensory changes into a transformed body image and self-perception. Unsuccessful adaptation, in contrast, is evidenced by experiences of physical and psychiatric symptoms such as unmitigated feelings of anxiety and depression, psychogenic pain, chronic fatigue, social withdrawal, and cognitive distortions (Livneh & Antonak, 1997).

Self-concept. One's self-concept and self-identity are linked to body image and are often seen as conscious, social derivatives of it (Bramble & Cukr, 1998; McDaniel, 1976). However, self-concept and self-identity may be discordant for many individuals with visible disabilities. The sense of self (i.e., self-identity), which is privately owned and outwardly presented, may be denied in social interactions with others who respond to the person as "disabled" first (i.e., focusing on appearance rather than identity), thereby losing sense of the person's real self (Kelly, 2001). The person's self-esteem, representing the evaluative component of the self-concept, gradually shows signs of erosion and negative self-perceptions following such encounters.

Stigma. The impact of stereotypes and prejudice acts to increase stigma toward people with CID (Corrigan, 2000; Falvo, 1999). Restrictions imposed by CID lead to deviations from several societal norms and expectations (e.g., utilization of health care services, occupational stability). They are, therefore, viewed negatively by society and result in stigmatizing perceptions and discriminatory practices. Moreover, when internalized by people with CID, these stigmatizing encounters with others result in increased life stress, reduced self-esteem, and withdrawal from social encounters, including treatment and rehabilitation environments (Falvo, 1999; B. A. Wright, 1983).

Uncertainty and unpredictability. Although the course of some CIDs is rather stable or predictable (e.g., amputation, cerebral palsy) most conditions may be regarded as neither stable nor predictable (e.g., epilepsy, cancer, diabetes mellitus, MS). Put differently, the insidious and variable course of these conditions is fraught with intermittent periods of exacerbation and remissions, unpredictable complications, experiences of pain and loss of consciousness, and alternating pace of gradual deterioration. Indeed the concept of "perceived uncertainty in illness" (Mishel, 1981, p. 258) was coined by Mishel to depict how uncertainty, or the inability to structure personal meaning, results if the individual is unable to form a cognitive schema of illness-associated events. Medical conditions, such as cancer and MS, that are marked by heightened levels of perceived uncertainty regarding disease symptoms, diagnosis, treatment, prognosis, and relationships with family members were found to be associated with decreased psychosocial adaptation (Mishel, 1981; Wineman, 1990).

Quality of life. The ultimate psychosocial outcome in rehabilitation practice is believed to be that of post-CID quality of life (QOL; Crewe, 1980; Roessler, 1990). As a global and multifaceted construct, QOL includes the following functional domains (Flanagan, 1982, Frisch, 1999): (a) intrapersonal (e.g., health, perceptions of life satisfaction, feelings of well-being), (b) interpersonal (e.g., family life, social activities), and (c) extrapersonal (e.g., work activities, housing). In the context of adaptation to CID, for QOL there are typically assumptions in two primary domains: successful restructuring of previously disrupted psychosocial homeostasis and attainment of an adaptive person-environment (reality) congruence. Furthermore, QOL is considered to be linked to a more positive self-concept and body image, as well as to an increased sense of control over CID, and QOL is negatively associated with perceived stress and feelings of loss and grief (Dijkers, 1997; Falvo, 1999).

CID-Triggered Responses

Clinical observations and empirical research on the psychosocial process of adaptation to CID have been marred by conflicting findings and heated debate. In this section, we focus on the most frequently experienced psychosocial reactions to CID as cited in the rehabilitation research and disability studies literatures.

Shock. This short-lived reaction marks the initial experience following the onset of a traumatic and sudden injury or the diagnosis of a life-threatening or chronic and debilitating disease. The reaction is characterized by psychic numbness, cognitive disorganization, and dramatically decreased or disrupted mobility and speech.

Anxiety. This reaction is characterized by a panic-like feature on initial sensing of the nature and magnitude of the traumatic event. Reflecting a state-like (i.e., situationally

determined) response, it is accompanied by confused thinking, cognitive flooding, and a multitude of physiological symptoms including rapid heart rate, hyperventilation, excess perspiration, and irritable stomach.

Denial. This reaction, also regarded as a defense mechanism mobilized to ward off anxiety and other threatening emotions, involves the minimization and even complete negation of the chronicity, extent, and future implications associated with the condition. Denial involves selective attention to one's physical and psychological environments. It includes wishful thinking, unrealistic expectations of (full or immediate) recovery, and at times, blatant neglect of medical advice and therapeutic or rehabilitation recommendations. Although denial may successfully mitigate anxiety and depression when used selectively and during initial phases of adaptation, its long-term impact is often considered maladaptive and life threatening (Krantz & Deckel, 1983; Meyerowitz, 1983).

Depression. This reaction, commonly observed among people with CID, is considered to reflect the realization of the permanency, magnitude, and future implications associated with the loss of body integrity, chronicity of condition, or impending death. Feelings of despair, helplessness, hopelessness, isolation, and distress are frequently reported during this time. Although depression has been found to be a widespread reaction among persons with CID (e.g., Rodin, Craven, & Littlefield, 1991; Turner & Noh, 1988), it is still unclear if it is (as some theoreticians and clinicians argue) a prerequisite to ultimate acceptance of the condition or attaining successful psychosocial adaptation (Wortman & Silver, 1989).

Anger/hostility. The reaction of anger/hostility is frequently divided into internalized anger (i.e., self-directed feelings and behaviors of resentment, bitterness, guilt, and self-blame) and externalized hostility (i.e., other- or environment-directed retaliatory feelings and behaviors; Livneh & Antonak, 1997). When internally directed, self-attributions of responsibility for the condition onset or failure to achieve successful outcomes are evident. In contrast, externally oriented attributions of responsibility tend to place blame for the CID onset or unsuccessful treatment efforts on other people (e.g., medical staff, family members) or aspects of the external environment (e.g., inaccessible facilities, attitudinal barriers). Behaviors commonly observed during this time include aggressive acts, abusive accusations, antagonism, and passive-aggressive modes of obstructing treatment.

Adjustment. This reaction, also referred to in the literature as reorganization, reintegration, or reorientation, comprises several components: (a) an earlier cognitive reconciliation of the condition, its impact, and its chronic or permanent nature; (b) an affective acceptance, or internalization, of oneself as a person with CID, including a new or restored sense of self-concept, renewed life values, and a continued search for new meanings; and (c) an active (i.e., behavioral) pursuit of personal, social, and/or vocational

goals, including successful negotiation of obstacles encountered during the pursuit of these goals.

CID-Associated Coping Strategies

The literature on CID-related coping strategies is vast (e.g., Moos, 1984; Zeidner & Endler, 1996). In this section, only a cursory overview of the most commonly reported strategies, directly related to coping with CID, is undertaken. First, however, the concept of coping is briefly discussed and its relevance to CID is illustrated.

Coping has been viewed as a psychological strategy mobilized to decrease, modify, or diffuse the impact of stress-generating life events (Billings & Moos, 1981; Lazarus & Folkman, 1984). Foremost among the defining characteristics of coping are those of (a) including both stable (i.e., trait-like) and situationally determined (i.e., state-like) elements; (b) accessibility to conscious manipulation and control; (c) hierarchical organization that spans the range from macroanalytic, global styles of coping (e.g., locus of control, optimism) to microanalytic, specific behavioral acts; and (d) being structurally multifaceted, including affective, cognitive, and behavioral aspects (Krohne, 1993; Zeidner & Endler, 1996). In addition, clinical and empirical studies of coping emphasize its (a) amenability to assessment by psychometric measures (there are currently over 20 psychological measures that purport to assess from 2 to almost 30 coping styles and strategies) and (b) divergent theoretical underpinnings (the nature of coping has been viewed differently by clinicians from various theoretical persuasions including psychodynamic, interpersonal, and cognitive-behavioral).

Research on coping with CID has spanned a wide range of conditions such as cancer, heart disease, spinal cord injury, epilepsy, MS, amputation, rheumatoid arthritis, and diabetes, as well as the experience of pain. Commonly assumed in these research endeavors is the existence of two broad categories of coping strategies, namely, disengagement and engagement coping strategies.

Disengagement coping strategies. These strategies refer to coping efforts that seek to deal with stressful events through passive, indirect, even avoidance-oriented activities such as denial, wish-fulfilling fantasy, self- and other-blame, and resorting to substance abuse (Tobin, Holroyd, Reynolds, & Wigal, 1989). This group of coping strategies is often associated with higher levels of psychological distress (i.e., increased negative affectivity), difficulties in accepting one's condition, and generally poor adaptation to CID.

Engagement coping strategies. These strategies refer to coping efforts that defuse stressful situations through active, direct, and goal-oriented activities such as information seeking, problem solving, planning, and seeking social support (Tobin et al., 1989). This group of coping strategies is commonly linked to higher levels of well-being, acceptance of condition, and successful adaptation to CID.

During the chronic, but often remitting and exacerbating, course of medical conditions and physical disabilities, coping strategies are differentially adopted to meet the fluctuating demands necessitated by the changing physical, psychosocial, spiritual, economic, and environmental needs of the person. The rehabilitation and disability studies literature suggests that coping strategies could occupy several roles in their relationship to psychosocial adaptation to CID. These include (a) direct or causal, such that their use might differentially determine or influence psychosocial adaptation; (b) indirect or mediating, such that their use acts to mediate between certain demographic (e.g., age), disability-related (e.g., severity or duration of condition), or personality (e.g., level of perceived uncertainty) variables, and outcomes of adaptation to CID; and (c) outcome variables, such that the type and valence of coping strategies are an indicator of how successful psychosocial adaptation is.

■ Assessment of Psychosocial Adaptation to CID

Over the past half century, a large number of measures of psychosocial adaptation to and coping with CID have been reported in the literature. In this section, only those psychometrically sound measures most frequently reported in the literature are reviewed. Readers may refer to Livneh and Antonak (1997) for a comprehensive discussion of these and other measures.

General Measures of Adaptation to CID

Millon Behavioral Health Inventory (MBHI; Millon, Green, & Meagher, 1979). The MBHI is a 150-item self-report questionnaire, organized into 20 clinical scales. The scales are classified into four domains that include (a) coping styles, (b) psychogenic attitudes, (c) psychosomatic complaints, and (d) a prognostic index. The MBHI seeks to (a) describe the psychological styles of medical service recipients, (b) examine the impact of emotional and motivational needs and coping strategies on disease course, and (c) suggest a comprehensive treatment plan to decrease the impact of deleterious psychological reactions. The strengths of the MBHI include its sound psychometric (i.e., reliability and validity) properties, clinical usefulness, and applicability to a wide range of medical and rehabilitation settings. Weaknesses include empirically unconfirmed domain structure and potential reactivity influences and response bias.

Psychosocial Adjustment to Illness Scale (PAIS; Derogatis, 1977; Derogatis & Lopez, 1983). The PAIS is a 46-item instrument designed to measure psychosocial adaptation to medical illnesses and chronic diseases. The scale can be administered both as a semistructured psychiatric interview by a trained clinician and as a self-report measure (PAIS-SR). In addition to an overall adjustment score, seven

subscales are provided. These include Health Care Orientation, Vocational Environment, Domestic Environment, Sexual Relationships, Extended Family Relationships, Social Environment, and Psychological Distress (i.e., indicating reactions of anxiety, depression, guilt, and hostility, as well as levels of self-esteem and body image). The strengths of the PAIS include the psychometric robustness of its scales, having both self-report and clinician interview forms, and the availability of norm scores for several medical conditions (e.g., cancer, MS, renal failure). Weaknesses include lack of data on possible response bias influences.

Acceptance of Disability Scale (AD; Linkowski, 1971). The AD Scale is a 50-item, 6-point, summated rating scale developed to measure the degree of acceptance of disability as theorized by Dembo, Leviton, and Wright (1956). Items are summed to yield a single score representing changes in one's value system following the onset of physical disability.

Major strengths inherent in the AD Scale include its theory-driven rationale, reliability, and use in a large number of English-speaking and non-English-speaking countries. Weaknesses are suggested by the lack of investigation of its factorial structure, its unidimensional approach to a complex construct, and lack of data on response bias influences.

Sickness Impact Profile (SIP; Bergner et al., 1976; Gilson et al., 1975). The SIP comprises 136 items that yield, in addition to scores on 12 subscales, a global scale score; 3 scales can be combined to create a physical dimension score (i.e., Ambulation, Mobility, and Body Care and Movement), 4 scales can be combined and yield a psychosocial dimension score (i.e., Social Interaction, Alertness Behavior, Emotional Behavior, and Communication), and the 5 remaining scales are viewed as independent categories and are typically scored separately (i.e., Sleep and Rest, Eating, Work, Home Management, and Recreation and Pastimes). Respondent-perceived impact of sickness is measured by directing the respondent to choose descriptors of currently experienced, sickness-related behavioral dysfunction.

The strengths of the SIP include its comprehensive and rigorous psychometric development and properties, extensive use with patients diagnosed with a variety of physical and health conditions, and the availability of a Spanish language version. Weaknesses may be related to its yet-to-be-tested factorial structure and susceptibility to defensiveness and response set.

Reactions to Impairment and Disability Inventory (RIDI; Livneh & Antonak, 1990). The RIDI is a 60-item, multidimensional, self-report summated rating scale. Its intended use is to investigate eight clinically reported classes of psychosocial reactions to the onset of CID. The eight psychosocial reaction scales include Shock, Anxiety, Denial, Depression, Internalized Anger, Externalized Hostility, Acknowledgment, and Adjustment. The strengths of the RIDI include its comprehensive psychometric development, scale reliability, and multidimensional perspective on adaptation to CID. Weak-

nesses are suggested by scant concurrent validity data, lack of normative data across disabling conditions, and potential confounding effects of response bias influences.

Handicap Problems Inventory (HPI; G. N. Wright & Remmers, 1960). The HPI is a 280-item checklist of problems believed to be attributed to the presence of physical disability. Respondents are asked to mark those problems that are caused or exacerbated by the existence of the condition. Items on the inventory are grouped into four life domains that include Personal, Family, Social, and Vocational subscales. The strengths of the HPI include domain comprehensiveness, its documented internal reliability estimates, and available normative data. Weaknesses include lack of supportive data on its validity, possible response bias, and its inordinate length.

Specific Measures of Adaptation to CID

A sizeable number of measures related to psychosocial adaptation to specific CIDs have been reported in the rehabilitation and disability studies literatures. Because of space constraints, these measures will not be reviewed here. Interested readers may refer to Livneh and Antonak (1997) for a comprehensive review of these scales. Readers may also wish to directly consult the following:

1. Measures of adaptation to cancer that include the Mental Adjustment to Cancer Scale (Watson et al., 1988)
2. Measures of adaptation to diabetes that include the Diabetic Adjustment Scale (Sullivan, 1979)
3. Measures on adaptation to epilepsy and seizure disorders that include the Washington Psychosocial Seizure Inventory (Dodrill, Batzel, Queisser, & Temkin, 1980)
4. Measures of adaptation to traumatic brain injury that include the Portland Adaptability Inventory (Lezak, 1987)
5. Measures of adaptation to rheumatoid arthritis that include the Arthritis Impact Measurement Scale (Meenan, 1982, 1986)
6. Measures of adaptation to spinal cord injuries that include the Psychosocial Questionnaire for Spinal Cord Injured Persons (Bodenhamer et al., 1983)
7. Measures of adaptation to visual impairments that include the Nottingham Adjustment Scale (Dodds, Bailey, Pearson, & Yates, 1991)
8. Measures of adaptation to hearing impairments that include the Social-Emotional Assessment Inventory for Deaf and Hearing-Impaired Students (Meadow, Karchmer, Peterson, & Rudner, 1980)

Counselors and clinicians who consider adopting traditional psychological measures (e.g., the Minnesota

Multiphasic Personality Inventory, Beck Depression Inventory, Spielberger's State-Trait Anxiety Inventory) to address psychosocial adaptation to CID must be cognizant of the following two issues:

1. Physical and physiological symptoms (e.g., fatigue, weakness, sleep problems) directly associated with a number of CIDs (e.g., spinal cord injury, MS, Parkinson's disease) often mimic indicators of depression and anxiety among members of these populations. Counselors who work with people with CID should therefore (a) pay careful attention and differentiate, whenever possible, the more authentic indicators of depression and anxiety (typically cognitive and affective correlates) from those associated with the condition's physiological concomitants and (b) gain understanding of the literature that has examined the confounding effects of CID-triggered physiological symptoms on the scoring and interpretation of traditional psychological measures (e.g., Morrison, 1997; Pollak, Levy, & Breitholtz, 1999; Skuster, Digre, & Corbett, 1992).

2. Most traditional psychological and psychiatric measures lack scoring norms based on responses from populations of people with CID. This lack of normative data for people with CID renders these measures suspicious, even misleading, when their findings are interpreted indiscriminately. Counselors who adopt, or contemplate modifying, psychological tests for use with people with CID should carefully review the *Standards for Educational and Psychological Testing* (American Psychological Association, 1999) and Bolton (2001) for specific suggestions on this matter.

Intervention Strategies for People With CID

Numerous theory-driven, reaction-specific, and clinically documented intervention strategies to assist people with CID successfully adapt to their conditions have been reported in the literature. In the following section, we review the major approaches to psychosocial interventions applied to people with CID.

Theory-Driven Interventions

These interventions focus on the clinical applications of widely recognized personality theories and therapeutic models to persons with CID and the perceived merits of their use with this population. Among the more commonly applied theories are psychoanalytic, individual (Adlerian), Gestalt (Perls), rational-emotive-behavioral (Ellis), cognitive (Beck), and behaviorist (Riggat, Maki, & Wolf, 1986; Thomas, Butler, & Parker, 1987).

When adopting theory-driven interventions, clinicians typically follow a three-step sequence. First, core concepts from a particular theory (e.g., defense mechanisms, feelings of inferi-

ority, unfinished life situations, irrational beliefs) are identified and examined. Second, the usefulness of these concepts, within the context of psychosocial adaptation to CID (e.g., understanding the process of grieving for loss of body parts or functions) is scrutinized. Third, the benefits derived from these concepts, for practical counseling interventions, for people with CID are assessed and, if deemed appropriate, are applied to their life situations. Readers may wish to refer to Chan, Thomas, and Berven (2002), English (1971), Livneh and Antonak (1997), Livneh and Sherwood (1991), and Shontz (1978) for detailed reviews of these interventions.

Psychosocial Reaction-Specific Interventions

These eclectic interventions aim at offering a logical match between specific psychotherapeutic strategies and those reactions (or experiences) evoked during the process of adaptation to CID (e.g., anxiety, depression, denial, anger). Worded differently, the counselor seeks to link specific counseling strategies with clinically observed, or client-reported, psychosocial reactions (Dunn, 1975; Livneh & Antonak, 1997; Livneh & Sherwood, 1991). It is generally argued that strategies regarded as supportive, affective-insightful, or psychodynamic in nature (e.g., person-centered therapy, Gestalt therapy, Jungian therapy) may be more useful during earlier phases of the adaptation process. In contrast, strategies viewed as more active-directive, goal-oriented, or cognitive-behavioral in nature (e.g., cognitive therapy, behavioral therapy, coping skills training) may be more beneficial during the later stages (Dunn, 1975; Livneh & Antonak, 1997; Marshak & Seligman, 1993). To illustrate the above rationale, two examples are provided. First, disability- or loss-triggered depression can be approached by encouraging the client to vent feelings associated with grief, isolation, guilt, shame, and mourning for the lost function (e.g., mobility, vision, health). Protracted depression can be further managed by reinforcing social contacts and activities and by practicing self-assertiveness, self-determination, and independent living skills. Second, reactions (feelings and behaviors) of self-directed or other-directed anger may be dealt with by teaching and practicing anger expression in socially sanctioned forms, such as the pursuit of artistic endeavors and, if feasible, sports-related activities. Other strategies could include practicing behavior modification techniques to reduce physically and verbally aggressive acts.

Global Clinical Interventions

These comprehensive clinical interventions are geared toward assisting people with specific CIDs (e.g., cancer, heart disease, spinal cord injury) in successfully adapting to their condition and its impact on their lives. More specifically, these interventions provide the client and his or her family and significant others with emotional, cognitive, and behavioral support. In addition, these interventions equip the client with adaptive coping skills that could be successfully adopted when facing

stressful life events and crisis situations. Among the most commonly encountered global clinical interventions are the following.

1. *Assisting clients to explore the personal meaning of the CID.* These strategies rest heavily on psychodynamic principles and focus on issues of loss, grief, mourning, and suffering. Emphasis is also placed on encouraging clients to vent feelings leading to acceptance of condition permanency, altered body image, and realization of decreased functional capacity. Rodin et al.'s (1991) three-phase approach to treating depression in medically impaired individuals best illustrates this strategy (i.e., assisting clients in expressing grief and mourning, providing clients with opportunities to seek personal meaning of their CID, and training clients to attain a sense of mastery over their emotional experiences).

2. *Providing clients with relevant medical information.* These strategies emphasize imparting accurate information to clients on their medical condition, including its present status, prognosis, anticipated future functional limitations, and when applicable, vocational implications. These approaches are best suited for decreasing initial levels of heightened anxiety and depression, as well as the potentially damaging effects of unremitting denial (Ganz, 1988; Razin, 1982).

3. *Providing clients with supportive family and group experiences.* These strategies permit clients (usually with similar disabilities or common life experiences) and, if applicable, their family members or significant others to share common fears, concerns, needs, and wishes. These experiences also allow clients to acquire greater insight and to gain social support and approval from other group participants, family members, and professional helpers. Common group modalities include educational groups, psychotherapeutic groups, coping-skills training groups, and social support groups (Roback, 1984; Seligman, 1982; Telch & Telch, 1985). Subramanian and Ell's (1989) group model for heart patients best exemplifies this approach because it incorporates (a) information on heart conditions and disability management, (b) coping-skills training to manage stressful life situations, and (c) cognitive skills teaching to manage maladaptive emotions.

4. *Teaching clients adaptive coping skills for successful community functioning.* These strategies, in a similar vein to those of group-based coping-skills training, focus on instilling in clients coping skills that will allow them to face a wide range of stressful conditions typically encountered by people with CID in physical, social, educational, and vocational settings. These skills include assertiveness, interpersonal relations, decision making, problem solving, stigma management, and time management skills. Craig and coauthors (Craig, Hancock, Chang, & Dickson, 1998; Craig, Hancock, Dickson, & Chang, 1997) have used a cognitive-behavioral therapy coping program to train clients who have sustained spinal cord injury. The authors' multifaceted approach uses relaxation techniques, visualization techniques, cognitive restructur-

ing, and social and self-assertiveness skills training to help participants cope with psychosocial difficulties encountered on release into the community.

Summary

Approximately 1 in 5 Americans is currently diagnosed with CID. People with CID often encounter physical, psychological, social, educational, financial, and vocational barriers that greatly interfere with their quality of life. In this article, we have attempted to provide counselors with the most useful and pragmatic concepts, processes, assessment tools, and intervention strategies related to psychosocial adaptation to CID.

When working with individuals who have sustained CID, counselors are commonly called to draw on their expertise in the areas of (a) stress, crisis, and coping with loss and grief; (b) the impact of traumatic events on self-concept, body image, and quality of life; and (c) the effects of disability-linked factors (e.g., uncertainty, unpredictability) and societal reactions (e.g., stigma, prejudice) on psychosocial adaptation to CID.

Counselors must also be cognizant of, and demonstrate clinical acumen when observing, clients' psychosocial reactions to their conditions and the external environment. Several CID-triggered responses (at times described as phases) have been discussed. These include (a) reactions of shorter duration that are more commonly experienced earlier in the adaptation process (e.g., shock, anxiety); (b) reactions of longer duration that normally suggest distressed and unsuccessful coping efforts (e.g., depression, anger); and (c) reactions that signal successful adaptation to the condition and renewed life homeostasis (adjustment).

Of the many measures available for assessing psychosocial adaptation to CID, six have been reviewed in this article. They were selected because of their (a) applicability to a wide range of CIDs, (b) sound psychometric development and structure, (c) frequent citations in the rehabilitation and disability studies literatures, and (d) clinical and research potential.

Assessment of clients' levels of psychosocial adaptation to their condition should pave the way to appropriate selection of intervention strategies. To this end, the article concludes with an overview of four psychosocial strategies most commonly applied to counseling people with CID. Reviewed were interventions based on innovative applications of traditional personality and psychotherapeutic interventions. Next, interventions that seek to address reactions linked to the onset of CID (e.g., anxiety, depression, anger) were highlighted. Finally, global, eclectic, clinical approaches that were typically developed for specific disabilities (e.g., cancer, heart conditions, spinal cord injury) were illustrated. The last group of interventions offers the counselor fertile ground for applying comprehensive, multifaceted approaches geared to meet the wide range of psychological, social, and vocational needs of clients with CID.

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