Chapter Highlights

- Current status of rehabilitation research and ethnic populations
- The participatory action research model and inclusion of diverse populations
- Relevancy of rehabilitation research to diverse populations
- Evidence based research and diverse populations
- Assets and limitations of using existing databases
- Cultural mistrust and postcolonial traumatic stress
- Conclusion
Only through diversity of opinion is there, in the existing state of human intellect, a chance of fair play to all sides of the truth.

*John Stuart Mill*

Since time immemorial, human beings have been overly concerned about their outward appearances and have held the belief that, somehow, the characteristics of the physique were reflections of the inner self. The philosophy of mind and body being two interconnected parts of the human unity may have inadvertently generated the notion of intimate interdependence of physique and personality. Even today, disability is considered a challenge. It is perceived as a misfortune that results in a very long and arduous journey through life unique to those with disabilities. As a result, the effects of spread continue to devalue and dehumanize the individual to an object of intervention. Spread is defined as the ability of a single characteristic to evoke inferences about the person as a whole. Thus, a person with a disability may be perceived as unhappy, eager to please, frustrated, child-like, and incompetent. Though society has made progress in becoming sensitive to the needs of this population, significant levels of prejudice, ignorance, and stereotypes continue to impact the quality of lives of people with disabilities (Dembo, Leviton, & Wright, 1956; Marinelli & Dell Orto, 1999; Wright, 1983).

In an effort to identify and explain the psychosocial effects of a disability, this chapter will focus on (1) an overview of selected models of conceptualizing disability in general and from a cultural perspective, (2) the effects of civil and women’s rights on the disability rights movement, (3) conceptualization of multiculturalism from an American perspective and its effects on disability in general, (4) stages of adjustment to a disability as a function of one’s environment, and (5) the role of culture and ethnicity in the acceptance of a disability. We are aware that a certain type of physical and mental health condition may cause specific coping, adjustment, and psychosocial issues for a person with a disability. It is beyond the purview of this chapter, however, to delve into specific implications of each type of disability. The focus is on the effects of disability in general, and as a function of a person’s contextual factors.
GUIDING MODELS OF ALLIED HEALTH

Chronic health conditions and disability, due to congenital anomalies or accidents or illnesses, are a natural part of life. Rapid medical and technological advancements have resulted in enhanced longevity, higher survival rates for people with life threatening illnesses, and an increase in the population of those with disabilities. More than 54 million Americans report some form of disability that interferes with one or more activities of daily living (ADL), and almost 50% of that population has a severe disability. There is a differential distribution of disability by age, gender, and ethnicity. Prevalence of disability is (1) higher in females than in males and among ethnic minorities than in the Caucasian population; (2) inversely proportional to educational level; and (3) directly proportional to poverty (National Institute on Disability and Rehabilitation Research [NIDRR], 2005). The hindrances imposed by functional limitations, prolonged treatment, subsequent social stereotypes, and an uncertain future can have significant physical, emotional, vocational, social, and economic affects on the person and significant others (Eisenberg, Gleuckauf, & Zaretsky, 1993; Shapiro, 1994). In order to address the unique socio-environmental challenges of those with disabilities, it is necessary to comprehend the principal dimensions of a few selected conceptual models.

MEDICAL MODEL AND SOCIAL MODEL

The following table presents a comparative discussion of two philosophically opposing models of disability (Hahn, 1988; NIDRR, 1999; World Health Organization [WHO], 2002).

<table>
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<tr>
<th>Medical Model</th>
<th>Social Model</th>
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<tr>
<td>1. Disability is a personal, biological, and physical problem, directly caused by trauma or other health condition. It is one of the oldest models linking western science to human body functions.</td>
<td>1. Disability is a socially created problem. It is a collection of interactive conditions, many of which are created by the social environment.</td>
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<td>2. Disease, impairment, disabilities, handicaps, disadvantage for an individual, limits or prevents the fulfillment of a role for that individual.</td>
<td>2. Disability is not an attribute of an individual rather it is a function of the external surroundings.</td>
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3. Disability requires medical care provided in the form of individual treatment by professionals. Therefore, the person, sum of his or her body parts, is an object of intervention.

4. Management of disability is aimed at cure or elimination of disability or disease. In other words, it advocates for the individual’s adjustment and behavior change.

5. At the political level, the primary mode of response is the change of healthcare policy. Due to its person-centered, reductionist, and body-mind-environment separationist foci, the model is challenged by disability activists.

The medical model promotes the elimination and prevention of disease and disability. For example, with reasonable effort, a condition like smallpox will be completely eradicated. It is just a matter of time. However, in parts of society where the nearest physician is 100 miles away, the next meal is several days away, and/or the effect of the color of the skin superimposes all other desirable human characteristics, the word disability can only mean invalidity and the need for charity. In communities where participation of all members is a dire necessity for survival, the medical model premised on the concept of “normal” people but applying only to those with disabilities, can promote wholesale rejection of individuals with disabilities. Because a large proportion of the socially disadvantaged population (including non-mainstreamed Americans and minorities) lives in environments as described above, policy making and service delivery based on the medical model will only enhance dependence on public assistance and reduce the potential for successful community integration (WHO, 2002).

The social model, on the other hand, challenges the age-old concept of natural linear progression from normality through disease to disability and social
exclusion. Since incarceration under despicable conditions, living in a segregated society, and destitution are not inevitable consequences of disease, there is a need to address contextual factors that affect the perception of disability. High prevalence of disability among those living in poverty and those experiencing lack of access to proper health care can be attributed to their exposure to new etiologies as a direct function of the high-risk life style and work environment. People of ethnically and linguistically diverse origins are more likely to live in poverty, be less educated, have lower access to medical care, experience malnutrition, give birth to babies with low birth weight, and be exposed to violence in their day-to-day lives. The differential distribution of disability according to age, gender, ethnicity, education, socioeconomic status, and geographic location warrants emphasis on dynamic interactions of the person and the environment. This shift in conceptualizing the phenomenon of disability encourages the development of innovative methods of helping people with various disabilities, including ethnic minorities, to achieve their fullest potential (NIDRR, 2005; WHO, 2002).

ENERGY MODEL

The concept of the energy model is that health and wellness are influenced by the body, mind, emotions, and the soul. This paradigm, generated by oriental philosophy and medicine some 500 years ago, re-establishes the innate connection between humanity and nature. Energy is omnipotent, omnipresent, omniscient, and the mother of all living and non-living beings. There exists a natural equilibrium among all types of matter that, in turn, produces peace, happiness, and health. Therefore, human health is linked to environmental health, which, in turn, is connected to the health of the universe. The concept of energy, the foundation for quantum physics, is the universal operating force. Humans owe most of their advancement to the discovery of energy in form of electricity. Therefore, the model focuses on the interdependence of all systems and all aspects of life (Trieschmann, 1995; Trieschmann, 2001).

The consequence of any change in the equilibrium of energy affects the entire system. Emotional disturbance, one of the principal causes of disharmony in human, often results in unnecessary drainage of energy that needs to be replenished. Continued emotional reactions to external events of day-to-day life, such as social stereotypes to disability, cause the body to remain out of balance for a prolonged period of time. This extended state of imbalance eventually leads to underlying and chronic physical disorders, e.g., pain, headache, cancer, ulcers, and cardiovascular diseases. It is essential, therefore, for people with disabilities to achieve energy balance by effectively managing emotional reactions to stressors and maintaining a healthy level of composure.
Medical diagnosis only considers the physiological cause of the disorder without looking at the patterns of human energy. One way to replenish the depleted supply of energy is to engage in meditation through tai chi, Shen Qi, and yoga. Lifestyle and behavior change is often necessary to reduce emotional disturbance by avoiding stressful situations (Trieschmann, 1995; Trieschmann, 2001). Happiness, a precursor to psychological and physical well-being, can be achieved by finding an optimal functional environment and gaining control over one’s mind (Csikszentmihalyi, 1993). As rehabilitation revolves around the concept of the whole person from womb to tomb, this relatively eastern paradigm provides the field with a credible theoretical and philosophical basis.

**MULTICULTURALISM FROM AN AMERICAN PERSPECTIVE**

The principal component of multiculturalism is diversity of opinion. It entails being uncritical, understanding, and respectful of values that are different from our own. If there is an opinion and an insight, it is worth being heard, not necessarily being agreed upon. Such consideration often helps dispel ignorance of other people and cultures, i.e., the causative agent of ethnocentrism and racial intolerance. By choosing to remain ignorant, we fail to realize the innumerable similarities of human kind and the potential of our competitors who can become our future partners in the continued prosperity of planet earth. In this era of globalization of resources that causes millions of people to live and work in cultures different from their own, myopic knowledge of human capital will fast become counterproductive. In other words, the survival of the Western civilization will increasingly depend on a global understanding of that part of the world where a major segment of the population lives, i.e., the developing countries (Blum, 1991).

Development of multicultural sensitivity and competence is a means to increasing one’s power, energy, and decision-making abilities by adjusting to the effects of different perceptions of the same situation. It is a person-specific process characterized by the following stages of gaining: (1) awareness of the common beliefs about the differences and similarities; (2) knowledge and insight of culturally learned assumptions; and (3) skills to effectively interact with people of different cultures (Pedersen, 1988). Among this diversity of values, cultures, morals, and lifestyles, the overarching question remains, what determines appropriateness or inappropriateness of a specific action?

Since multicultural awareness is a personal responsibility meant to be fulfilled in a social context, a comparative discussion of western and non-western perspectives is in order. Western belief is centered around mastery and control of nature, aggressive and highly competitive quest for individualism, a perfect body image, a time driven and action oriented lifestyle, and the concept
of people being products of their environment. However, the concepts of time, social relationship, meaning of existence, and human worth vary widely between cultures and religions. The following table presents a brief, but incomplete, comparison of beliefs, traditions, and life styles of five different cultures (Blum, 1991; Sue & Sue, 1990).

<table>
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<tr>
<th>African American Indian</th>
<th>Asian</th>
<th>Hispanic</th>
<th>Islamic</th>
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<tr>
<td>1. A person is a function of the entire community.</td>
<td>1. Non-violence and pacifism is the way to end suffering and promote well-being.</td>
<td>1. Family traditions and family unity are important aspects of life.</td>
<td>1. Lifestyle must be congruent with the specifications of the Koran.</td>
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<td>2. Due to high poverty, economic needs are more important than civil rights.</td>
<td>2. Existence in harmony with nature and mother earth.</td>
<td>2. A strong belief that sacrifices in this world will promote salvation.</td>
<td>2. Religious rules are stricter for women than for men.</td>
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<td>3. Importance is on non-verbal behavior.</td>
<td>3. The spirit is immortal and is a part of all humans, plants, and animals.</td>
<td>3. Silence, lack of eye contact, and restraint of feelings are signs of respect.</td>
<td>3. Present is more important than past and future.</td>
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<tr>
<td>4. It is important to learn from history and tradition.</td>
<td>4. People have an innate ability to grow positively.</td>
<td>4. Humans must accommodate nature and not try to change it.</td>
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Cultural differences encountered by a person with or without a disability are functions of one’s country of origin, unique social background, and experiences with inequality.
There are three components geared to minimize the affects of perceived diversity among people. First, anti-racism promotes the belief that all humans are equal. One aspect of anti-racism is learning to perceive intended or unintended patterns of racism and when it is occurring. Second, multiculturalism entails becoming aware of one’s own cultural identity, respecting and learning about other cultures, and valuing the richness and worth of diverse religious or cultural groups. Third, sense of community embraces both ethnic and cultural differences (Blum, 1991). As of 2002, about 11.5% of the American population was foreign-born, 17% is ethnic minority, and the prevalence of disability is quite high in this population (Stone, 2005). Coming to terms with the myriads of differences in the American pluralistic community is the only way to promote a sense of belongingness and shared humanity among its stakeholders (Bellah, 1985). The field of rehabilitation is no exception.

EFFECTS OF SOCIAL MOVEMENT

Rights are the basic tenets of moral and social ethics. Existence of rights, both human and civil, enables a person to engage in behaviors or make claims against another individual, or society as a whole. Rights are anti-majoritarian in nature and de-emphasize the salience of collective good. People have human rights solely because they are human. The major components of human rights are thought to be globally applicable. Civil rights encompass the basic rights of a person as a member of society, e.g., rights to vote, assemble, and speak. The United Nations’ Universal Declaration of Human Rights was unanimously accepted in 1948 as a proof of its worldwide applicability. However, more than five decades after its ratification, the question of its universality or lack thereof still looms large over humanity (May, Collins-Chobanina, & Wong, 1998).

In spite of the existence of this U.N. Declaration and the Constitution of the U.S., structured inequality on the bases of ethnicity, gender, health status, and socio-economic level continues to prevail in all spheres of American society. Assimilation theory, the most common mode of studying social relations, attributes the perceived deficiencies of immigrants of color to their biological and cultural identity. As a result, victim blaming became the principal criterion in explaining racial discrimination. One reason for such an erroneous finding was the focus of assimilation studies on European immigrants rather than American Indians and Hispanics who have settled in the American mainland long before the arrival of the Mayflower (Aguirre & Baker, 2000). The investigation of the historical roots of institutional racism has repeatedly established inappropriateness of subjugation of a particular group of people in the U.S. The inequitable treatment and segregation of African Americans, Asians, American Indians, Hispanics, women, and people with disabilities...
prompt many to enquire, are human rights universal in scope or do they vary according to gender or ethnicity (May, Collins-Chobanina, & Wong, 1998)?

**Civil Rights of African Americans and Women**

Public awareness of and interest in ethnic populations began to escalate in the 1950s and gained momentum in the 1960s. The movement that was initiated in Montgomery, Alabama by the bus boycott in 1955 culminated in the Civil Rights Act of 1964. The African American “Black” power movement acted as a catalyst to generate sensitivity towards the unique needs of people who were disadvantaged, powerless, and disenfranchised, including racial minorities, women, people with disabilities, the elderly, gays, and lesbians. Due to heavy immigration, high birth rate among immigrants, and changing ethnographic composition of the country, an increasing need to respect the human rights of the people of diverse cultural origins was felt. The American public was forced to recognize the inequities of the “separate but equal” policies (Faragher, Buhle, Czitrom, & Armitage, 2003). This realization prompted the advent of international activism geared to liberate another segment of the “oppressed class,” the women.

“Gender is what culture makes out of the raw material of biological sex” (Unger & Crawford, 1996, p. 18). Since it is impossible for men and women to function in an environment with no expectation for gender-related behavior, a system of power relations between the two genders is the center of all human interactions. As a direct consequence of the largely male driven social norms and expectations, the status of women is often relegated to that of minorities. Discriminations encountered by women and people of ethnic origin, therefore, show striking similarities (Enns, 2000).

Although non-African American women did not experience slavery like the African Americans, women in general did not have the right to vote until the 20th century and lacked many of the legal protections enjoyed by Caucasian men. Therefore, strategies enacted to reduce the inequality between the mainstream and minority populations were also applicable to women (Hinman, 2000). In the 1970s, the change in the social status of minorities evoked a strong belief in the government’s power to initiate legal actions for addressing social inadequacies. Several pieces of legislation were passed to dismantle workforce barriers for women. The women’s liberation movement acted as a catalyst to the implementation of affirmative action programs, state equal opportunity laws, and the establishment of women’s studies programs and research centers (Bunch, 1998).
RIGHTS OF PERSONS WITH DISABILITIES

People with disabilities are the largest group of minorities in the U.S. The attitudes of the mainstream population toward minorities often predict their impressions of people with disabilities. Although historically these two groups have shared common problems, there are a few significant differences between minorities and people with disabilities. First, there is a lack of group endorsement of behavior typical to a particular disability. Since there is no fixed social norm indicative of the type of disability, most people with disabilities are expected to imitate a “normal” state as closely as possible. There is some resistance from both people with and without disability to behaviors that unnecessarily draw attention to the disability. Contrary to this largely American mainstreamed expectation, certain ethnic groups, such as American Indians, take pride in their unique characteristics (Wright, 1980).

Second, the difference of a person with a disability is not usually shared by other members of his/her family. Racial characteristics are genetic and, therefore, inherited by virtue of being born in that family. On the contrary, a person with a disability may often be the only member of a family to have the specific condition. As a result, children are often unaware of the existence of others with a similar condition and do not affiliate with any particular minority group. As a result, the psychological make-up of minorities is quite different from those with disabilities. In spite of the above dissimilarities, any changes in the social and economic condition of groups disadvantaged by virtue of race, religion, gender, and ethnicity were generally accompanied by parallel transformation in the status of people with disabilities (Wright, 1980). For example, the civil rights movement in the early 1960s was followed by the independent living movement in the mid 1960s and incorporation of Sections 501-504 of the Rehabilitation Act in 1973.

CONTEXTUAL AND MULTICULTURAL ISSUES IN ACCEPTANCE OF LOSS

The existence of disability often causes a person to feel devalued, incomplete, and almost ashamed of one-self. The onset of a sudden traumatic event or insidious condition produces an emergency for the person and the family. The following section presents a brief account of how disability is treated in different cultures. In the Hindu culture, the existence of a disability is believed to be the cause of wrong doing in a previous life. As a result, there is little sympathy for those with disabilities. The attribution of the responsibility for disability is an important factor in determining people’s attitude (Hanks & Hanks, 1948). In Nordic mythology, Gods have disabilities. Some believe that suffering is a test for high-level future pursuits. Suffering provides deep insight into life and is a means of self-sacrifice to achieve higher purposes (Wright,
1983). It is a fact that the prevalence of disability is high among the elderly. However, with age comes wisdom. American Indians, therefore, revere the elderly as the most knowledgeable and often having a connection between life and the afterlife (Marshall, 2001).

The drastic change in body image, functional capabilities, social role, and individual autonomy produced by disability often trigger a sense of tremendous loss and self-pity. The person and the family feel the absence of something valuable and experience a sense of misfortune. In an effort to keep the issue of disability from becoming a social reality, the person tries to conceal the effects of disability as much as possible. If concealment is not possible, the person makes himself or herself believe that the effects of the disability are not significantly limiting, i.e., as if nothing has happened. This “as if” behavior, feeling of inferiority, and effort to “idolize the normal standards,” confirm one’s belief that disability is, in fact, a punishment. These reactions to disability are often the first steps toward the striving to comprehend the importance of accepting one’s disability and adjusting to a new body image. Ethnic minority groups that are often devaluated by the American mainstream experience a heightened sense of loss and anger following the onset of a functional limitation. As disability is an inextricable part of one’s identity, denial of its existence may only mean that there is a need to restructure the basis of a person’s entire value system (Livneh & Antonak, 1997; Wright, 1983).

The issues of acceptance and denial of disability are considered two mutually exclusive responses to a chronic condition resulting in functional limitations. Denial, characterized by a failure to accept one’s disability, is often a precursor to poor psychosocial adjustment (Stewart, 1999) and compromised mental health status (Matthews & Harrington, 2000). Although the above perspective is quite prevalent, but not universal, it is important to briefly discuss the various stages of adjustment to a disability. The following paragraphs will provide a brief summary of the theories of adjustment to disability in general, and modes of facilitating community integration of people with disabilities.

**STAGES OF ADJUSTMENT AND ADAPTATION TO CHRONIC ILLNESS AND DISABILITY**

Humans have a powerful need to feel connected through meaningful, regular, and positive interactions. According to Daneshpaur (1998), Neumark-Sztainer, Story, French, and Resnick (1997), Newcomb (1990), and Rosen (1999), the concept of connectedness includes a self-in-relation-to-others component. Some refer to the connectedness as relationships with other individuals and systems. In other words, it is an enduring experience of self in relation to the world. When this fundamental human need is not addressed, a
person may experience negative impact on health, adjustment, and well-being. Psychological distress, social isolation, and dearth of purpose in life are other significant consequences of lack of connectedness with others for an extended period of time (Townsend & McWhieter, 2005). The impact of connectedness to self, others, and a purpose of life can be significant in the life of a person with a disability. In this regard, a brief discussion of cultural differences in connectedness will be in order.

As per Tamura and Lau (1999), many cultures demonstrate significantly more preference for greater connectedness. The perception and practice of individualism and collectivism vary as a function of culture. For example, Rude and Burham (1995) state that many non-western, minority, and non-European American societies are more community-oriented and are thought to be more connected as individuals and group members than the U.S. mainstream. According to Wong (1997), a strong feeling of connectedness to one’s ethnic group is often related to educational expectations, resiliency, and perceived positive peer characteristics. It is apparent that social and cultural connectedness is an important determinant of psychosocial adjustment for people with and without disabilities (Townsend, 2003). The various stages of adaptation to disability, therefore, must be considered in light of the above-mentioned concept.

Adaptation to any form of life altering loss such as injury, illness, disability, and death, is often characterized by the phases of shock, realization, denial, depression, anger, hostility, acknowledgment, and adjustment. These stages are not sequential and can be revisited several times in no particular order on the way to adjustment to a disability (Antonak & Liveh, 1995; Bray, 1978; Russell, 1981; Shontz, 1965).

Shock is the initial phase of heightened emotional reaction to the onset of a disability or diagnosis of a life-threatening condition. It may be characterized by overwhelming depersonalization, a sense of loss, and psychological numbness. Realization of the magnitude of the disability often produces anxiety, panic, confusion in thinking, fear of death, uncertainty about the future, and purposeless over-activity. Denial or defensive retreat is a significant but problematic form of coping strategy against painful realization of the long-term effects of a disability or a disease. A person in denial often experiences wishful and unrealistic expectation of recovery, i.e., I am going to recover fully and walk out of this hospital. Depression may accompany an initial accurate understanding of the nature of the disability or loss. This is especially noted among persons experiencing a sudden onset of disease or disability. It is a natural grief reaction to loss associated with feelings of distress, helplessness, and hopelessness.

Anger, characterized by feelings of guilt, may be perpetrated by self-directed resentment and self-blame. Mostly reported by people with adventitious
chronic disability, anger often results in self-destructive behaviors and suicidal ideation. Hostility, often directed toward other people and the environment believed to be responsible for the condition, is an effort to retaliate against functional limitations. Obstruction of treatment, verbal aggressiveness and criticism, and feelings of antagonism are some of the external manifestations of this phase. Acknowledgment and adjustment is the final phase of adaptation. This acceptance phase is characterized by an individual’s emotional readiness to be realistic about the functional limitations, to realize one’s self-worth as a person with a disability, and to start making use of his or her newly discovered potentials for a productive life. The order, duration, and repetition of these stages largely depend on an individual’s feeling of physical and psychological well-being in connection to self and the environment.

**DISABILITY IN THE CONTEXT OF MASLOW’S HIERARCHY OF NEEDS**

In western society, it is traditionally believed that a person’s self-worth and self-esteem can be developed from a sense of personal achievement. In other words, a good way to enhance one’s self-esteem is to offer plenty of opportunities to experience success. At par with this belief, standards of performance are often changed to allow completion of a task (with or without accommodation) by a person with a disability, and thereby foster trust in his or her abilities. Contrary to the general anticipation, such practices not only diminish society’s expectation of a person with a disability but also help the person learn that his or her worth as an individual is contingent upon being able to fit into the prescribed norms (Villa, Thousand, Stainback, & Stainback, 1992). Therefore, it is essential for people, in general, to be able to live and be accepted in the context of a community.

Maslow (1968 and 1970) expounds on the importance of satisfying personal needs for physiological (food, water, shelter, and warmth), safety (security, freedom from fear, and stability), and love (friendship, family, and belongingness) before attempting to self-actualize. For the first time, the need for community as a function of connectedness, relatedness, and interdependence is emphasized as a pre-requisite for self-sufficiency. Additionally, it professes that the need for self-actualization implies that a person has the required abilities to become proficient to a certain level. However according to Villa, Thousand, Stainback, and Stainback (1992), society has a unique way of identifying the “gifted” and the “mediocre” and providing the “gifted” with the opportunity to develop the areas in which they naturally excel. Often people with disabilities, with their apparent or unapparent limitations, do not appear to possess the need to self-actualize as per society’s pre-existing standards. In addition, people with
disabilities from non-mainstreamed ethnic backgrounds experience further lack of social expectation and support as a direct consequence of their cultural affiliation and value differences with the mainstream. This conflict between American core values and the reality of life for citizens across the nation continues to undermine the potential of minorities with disabilities.

As the central tenet of the western society, uniformity becomes the criterion for belongingness and diversity the criterion for exclusion. The general consensus is one must earn the right to belong through physical (appearance), academic, professional, and social achievements. This leaves people with disabilities with two options, both with significant negative effects for the target population. First, they can decide that the standards are too difficult for them to accomplish and resign themselves to feelings of inadequacy. Second, exert considerable effort, at the cost of one’s overall quality of life, to gain acceptance through achievement (Villa, Thousand, Stainback, & Stainback, 1992). It is imperative, therefore, that inclusion and belongingness be adopted by the stakeholders in rehabilitation as cornerstones for facilitating a person’s adjustment to and minimizing the effects of a disability.

**Value Changes in Acceptance of Disability**

According to Dembo, Leviton, and Wright (1956) and Wright (1980), adjustment to and acceptance of disability are characterized by changes in the value system that helps one perceive the loss as non-devaluing. The following are the components of value change.

*First, enlargement of the scope of value.* During the period of adjustment, a person is overwhelmed by the need to address the physical and psychological effects of disability. As a part of the shock reaction, disability becomes the center of one’s entire existence. At this time, the person must learn to genuinely appreciate other existing values in addition to the one(s) lost. This renews interest in satisfactions that are accessible and assists in acceptance of the loss.

*Second, subordination of the importance of physique relative to other aspects of the person.* Although a person is convinced that life is worth living, he or she may still harbor deep-rooted feelings about perceived consequences of the loss. This may either be attributed to overemphasis on physical normalcy or to insufficient weight placed on other values. In other words, the potency of physique far over weighs the satisfactions derived from the accessible values in life. The value of outward appearance is directly proportional to the effect of physique as a prime mover.

*Third, containment of the effects of disability so as not to overshadow other aspects of a person.* Spread often results in false perceptions about the effects of disability in many facets of life. Since all aspects of life are not affected by disability and people’s perceptions of its effects are largely
misconstrued, it is necessary to conceptualize disability as a possession and not as a personal characteristic. Separation of disability from the holistic person reduces its devaluing effects. For example, if physical abilities were viewed as tools used to perform actions, one could substitute for an impaired tool, i.e., doing it another way. Crutches, wheelchairs, leg braces may be considered substitutes for walking.

Fourth, transformation of comparative-status values to asset values. The characteristics of a person, such as the person’s looks, may carry status implications for persons who are evaluating themselves. Status judgments are often made by comparing a person against a standard of presumed average. The concept of physique as an asset value promotes the importance of the residual capabilities rather than the functional limitations.

**Role of Spirituality in Adaptation to Disability**

Disability poses several challenges to the achievement of goals and desires. A logical consequence of such hindrance and frustration is anger. Anger is a part and parcel of the (1) overwhelming grief cycle, (2) social stigma and stereotypes, (3) experiences of pain and vulnerability, (4) loss of control, autonomy, equality, and power, (5) lack of self-confidence resulting from the knowledge of functional limitations, and (6) reduced self-worth and image that often follow the advent of a disabling condition. Anger is an attempt to retrieve choice, respect, freedom, and self-importance (Thompson, 1985). Expression of anger is considered an important step toward spiritual and psychological growth and subsequent adjustment to a disabling condition.

Anger, the inner energy, and one of the significant facts of life, can promote justice, enhance health, and facilitate positive lifestyle changes. When repressed or denied, anger can only cause ill health, self-destructive behaviors, hopelessness, and generalized devastation in life. Failure to express anger often causes depression, guilt, self-blaming attitudes, withdrawal from outside contacts, and prolonged frustration. In addition, suffering is caused by fatigue as a result of (1) living with a disability, (2) needing to struggle for one’s rights and equal opportunity, (3) educating people in one’s surrounding, and (4) always being under the effects of the disability (Campbell, 1986; McClosky, 1986). The most common form of coping response is to be angry with God and to try to find meaning in the problem of suffering. One way of addressing this issue is to fearlessly challenge God with the question of why. In order to heal, the pain of suffering must be honestly presented before God. Repressing this anger will only cause one’s relationship with God to weaken. Confronting God and forming a dialectic relationship with him or her will re-establish one’s faith in God. One can both confront and obey God. “Both are spiritual acts; discovering when each is appropriate in the life of faith requires discernment” (McCarthy, 1995, p. 104).
From time immemorial, humans were at the mercy of Mother Nature. Religion was often considered a foundation of life and a spiritual consciousness of God. Even currently, the sense of God’s presence often contributes to one’s sense of security and hope or optimism. As per Dr. Paul Pedersen, issues of spirituality and culture always go together. As most religious behaviors and spiritual states are culturally learned, it is important to understand them in terms of where the behavior was learned and displayed (Cartwright & D’Andrea, 2005). It is important to fully understand the individualized perception of God in the process of rehabilitation.

Both spirituality and rehabilitation are journeys of discovery, i.e., paths to experiencing the readiness for a new awareness—defining the self, and settings goals for the future (Nosek, 1995). When operationalized, the above concepts strive to invigorate the person as a whole. There exists a direct link between holistic thinking and medical concerns. The words holy and holistic have originated from the Greek word “holos” meaning whole. “Holos,” on the other hand, is closely related to the Greek words for heal and health. Religion has traditionally played a significant role in treating medical conditions and addressing health care issues (McCarthy, 1995). Indigenous healers and local religious leaders, such as gurus in Indian culture and medicine men in African countries, continue to be the main source of health care for millions who value the importance of being one with nature and the role of a formless higher power in their lives. The World Health Organization recognizes indigenous healing or traditional medicine as the “knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental or social disequilibrium and relying exclusively on practical experience and observation handed down from generation to generation, verbally or in writing” (WHO, 1978, p. 3). On a futuristic note, it can be stated that psychoneuro-immunologists have empirically established the influences of metaphysical practices and inner energy on a number of physical phenomena such as mental states and functions of the immune system (McCarthy, 1995). It is imperative, therefore, that the immense power of this natural human energy be utilized to promote acceptance of disability and loss.

CONCLUSION

The dynamic process of adaptation is characterized by a series of highly individualized steps determined by the interaction of (1) psychodynamic and disability-triggered phases of adaptation, i.e., short- or long-term psychosocial reactions to disability, and (2) a group of intrapersonal (biopsychological), interpersonal (sociocultural), and extrapersonal (environmental) factors, i.e., contextual issues (Livneh, 2001). Although several theories have been proposed,
adjustment to disability should essentially be viewed as an evolutionary, changing, highly individualized, and temporarily ordered hierarchical process. The sequential nature of the process is dependent on factors such as the type of disability, nature of onset, pre-disability personality, cultural identity, social environment, and perception of the residual functional abilities. In other words, the process is characterized by (1) learning the techniques to live with a disability, (2) making the most of one’s residual abilities, and (3) striving to have a productive and satisfying life (Antonak & Livneh, 1991; Carpenter & Strauss, 1977; Sue & Sue, 1990; Trieschmann, 1988).

The literal meaning of rehabilitation is return to something. This something holds different meaning for different people and changes its meaning with transforming life situations. For those with congenital disability, rehabilitation is a misnomer because they have not known any other way of living. Instead of returning, they should grow and enhance their capabilities in the dimensions accessible to them. Adaptation to a disability or a chronic condition is a life-long process of successfully coping with the loss of health, transformed social standing, environmental restrictions, and reduced vocational roles (Livneh, 2001; Nosek, 1995). Rehabilitation is the process of defining or re-defining oneself and reveling in the fact that one’s spiritual essence is eternal and unchanging.
REFERENCES


