

Psychological Aspects of Developmental and Physical Disabilities

A CASEBOOK

Michel Hersen
Vincent B. Van Hasselt
editors

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Preface and Acknowledgments

In the 1980s increased psychological attention has been placed on individuals (both children and adults) suffering from a variety of developmental and physical disabilities. At least four factors have contributed to the increased clinical and research interest in this area. First, of course, is the fact that innovation in medicine has resulted in greater longevity of disabled people, thus highlighting the importance of continued psychological care throughout the various developmental stages of life. Second, as a function of the staggering financial costs involved in care and rehabilitation, greater public scrutiny of the problem has eventuated. Third, the much delayed legislative initiatives (e.g., wheelchair access in public facilities) have helped to diminish and dispel the negative stereotypes held by the public at large. And fourth, but equally important, recent societal and professional concern about the increased possibility of abuse and neglect of developmentally and physically disabled individuals (at all ages) has underscored the critical psychological features in their care.

Surprising as it may seem, no casebook details the kinds of psychological interventions applied to the spectrum of developmentally and physically disabled people could be found. Indeed, we thought that by developing such a book a gap in the literature would be filled for professionals working with disabled people, such as special educators, psychologists, social workers, rehabilitation workers, physical therapists, nurses, and psychiatrists. We feel that, as a consequence of the obvious developmental and physical disabilities, too often the psychological needs of such individuals are not given sufficient attention.

The book is divided into two parts. Part I gives an overview of the issues and their diagnostic and medical considerations. Part II comprises 14 chapters that consider many of the major developmental and

physical disabilities. Each chapter follows an identical outline to enable the reader to make cross case comparisons with ease: 1. Description of the Disorder; 2. Case Identification; 3. Presenting Complaints; 4. History; 5. Assessment; 6. Selection of Treatment; 7. Course of Treatment; 8. Termination and Follow-up; and 9. Overall Evaluation.

Many people have contributed their time and expertise to this book. First, we thank our respective contributors for their willingness to share their thoughts on the clinical care of developmentally and physically disabled individuals. Second, we thank Mary Newell, Mary Anne Frederick, Jenifer McKelvey, and Karen Drudy for their technical help. And finally, we thank Terry Hendrix, our editor at Sage, for his willingness to publish and his patience.

Michel Hersen
Vincent B. Van Hasselt

PART I

INTRODUCTION

Chapter 1

Overview

Vincent B. Van Hasselt
John R. Lutzker
Michel Hersen

Introduction

During the past decade there has been an increasing awareness of the pivotal role that psychologists may play in improving the life situation of persons with developmental and physical disabilities. This was perhaps most clearly illustrated in a May, 1984, special issue of *American Psychologist*. Specifically, this issue was devoted to a discussion of relevant issues, research strategies, and treatment approaches with disabled individuals. These articles transversed a wide range of topics, reflecting areas that warrant greater attention from psychologists and other mental health professionals who work with disabled persons. Some of these include: social functioning, attitudes toward disability, mental health problems, adjustment and family reactions to disability, the increasing prevalence of developmental and physical disability, and legal and legislative initiatives with disabled populations. These issues continue to pose unique challenges to the various professionals actively involved in evaluation and remediation efforts with the disabled. A brief overview of these salient issues is provided in the sections below.

Social Attitudes and Adjustment

In one of the articles featured in the May, 1984, *American Psychologist*, Asch (1984) addressed the difficulties of interpersonal adjustment and social discrimination encountered by many persons with some form of disabling condition. As Asch cogently pointed out, inadequate socialization, social stigma, and stereotyping have been major factors in the acceleration of assessment and intervention activities with disabled persons, who, historically, have been viewed by many as socially incompetent, helpless, and dependent (Jackman, 1983).

The pervasive negative social attitudes of nondisabled individuals toward those with disabilities, and the problems encountered by disabled persons in social adaptation have been documented for several years now (e.g., Dion, 1972; Kleck, 1968; Van Hasselt, 1983). Indeed, in an analysis conducted over two decades ago, of attitudes of nondisabled persons toward those with disabilities, Siller, Chipman, Ferguson, and Vann (1967) found the following dimensions to be paramount: generalized rejection (unpleasant personal reactions), interaction strain, distressed identification (i.e., anxiety by the nonhandicapped regarding their own potential vulnerability), imputed functional limitations, rejection of intimacy, authoritarian virtuousness (i.e., appearing to be supportive of the disabled but actually negative in attitude), and inferred emotional consequences. The latter factor refers to the common view that a disability negatively affects the character, social valence, and/or emotional status of the disabled individual. Asch (1984) concluded that "the presence of someone who actually is or is thought to be disabled arouses in the nonhandicapped person a variety of emotions that, at the very least, hinder ordinary social interaction. Nonhandicapped people prefer to avoid social contact with the disabled or behave more formally and in distorted ways if they are forced to interact with handicapped persons" (p. 532).

Psychological research also has provided a convergence of empirical data indicating that many disabled children and adults are socially isolated (e.g., Eaglestein, 1975; Van Hasselt, 1983), receive inaccurate feedback regarding their interpersonal behavior from their environment (Richardson, Goodman, Hastorf, & Dornbusch, 1961), and have fewer and more inadequate socialization experiences than nonhandicapped individuals (Kleck, Richardson, & Ronald, 1974). It appears that Richardson (1976) was quite accurate when he contended that "no further

research is needed to show that it is socially disadvantageous to be . . . handicapped in initial social encounters" (p. 32).

The heightened awareness of the need for enhanced socialization in persons with disabilities has led to a proliferation of social skills interventions targeting a wide variety of disabled groups. Some of these include the blind and visually impaired (Farkas, Sherick, Matson, & Loebig, 1981; Van Hasselt, Hersen, Kazdin, Simon, & Mastantuono, 1983), deaf (Lemanek, Williamson, Gresham, & Jensen, 1986), spinal-cord injured (Dunn, Van Horn, & Herman, 1981), mentally retarded (Matson & Zeiss, 1978; Turner, Hersen, & Bellack, 1978), as well as autistic (Strain, 1983) and multihandicapped (Sisson, Van Hasselt, Hersen, & Strain, 1985) children. Further, the goals of skills-training endeavors have varied considerably and have ranged from attempts to reduce maladaptive responses (e.g., self-stimulatory behaviors) that interfere with effective social interactions (Farkas et al., 1981) to elevating levels of molecular components (e.g., eye contact, response latency) requisite to socially skillful interchanges (Lemanek et al., 1986; Van Hasselt et al., 1983). More recently, approaches that use nondisabled peers as skill "trainers" have enjoyed success in improving the social valence and acceptability of disabled children (see Sisson et al., 1985; Strain, 1983).

Mental Health

The psychological adjustment of disabled individuals also has been the focus of increased clinical and investigative attention in recent years. Increased activity in this area is attributable to evidence of emotional and/or behavior problems in a disproportionately large number of disabled persons. For example, psychological assessment research has revealed higher levels of psychopathology (e.g., anxiety, depression) in many visually impaired children and adults relative to nonhandicapped controls or sighted norms (e.g., Bauman, 1964; Jan, Freeman, & Scott, 1977; Van Hasselt, Kazdin, & Hersen, 1986). A similar pattern of results has been reported with hearing-impaired persons (Gentile & McCarthy, 1973; Jensema & Trybus, 1975; Vernon, 1972). In their extensive review of work with the latter group, Matson and Helsel (1986) concluded that "psychiatric problems, especially personality disorders, neurosis and behavior disorders in children and adults are reported to be particularly prevalent in the hearing impaired" (p. 23). Mental health problems of the mentally retarded also have been

examined empirically (see Matson & Andrasik 1983). Some difficulties that have been the focus of psychological assessment and intervention with these individuals include depression (Matson, Senatore, Kazdin, & Helsel, 1983), self-injury (Griffin, Locke, & Landers, 1975; Matson, Stephens, & Smith, 1978), and aggression (Repp & Brulle, 1981).

Adjustment to Disability

Of particular interest to psychologists and other mental health professionals has been the process of adjustment to serious disability by both the disabled person and family system. The stages of adjustment have been viewed as parallel to those described in the literature on trauma (e.g., Kübler-Ross, 1969). For example, Weller and Miller (1977) characterize responses to spinal cord injury as shock, denial, anger, depression, and acceptance of adjustment. *Shock* is considered a protective mechanism, which may be psychological or physical depending on the nature of the disability. This phase is usually of relatively brief duration. *Denial* is used by the disabled individual to protect him- or herself from the devastating implications of a severe impairment. While gradually relinquished as a function of accommodation to the disability, denial may be dysfunctional if it interferes with intervention or rehabilitative efforts.

As a reaction to the physical and psychological injury incurred, the perceived inequity of the impairment, and the life changes the individual is forced to make, *anger* may be observed concurrent with or following denial. While seen as a normal part of the adjustment process, anger too, may impede rehabilitation if it becomes excessively disruptive. *Depression* reflects the disabled person's feelings of hopelessness, despair, and negative expectations for the future. It may be observed at any point during adjustment. Depression also is associated with feelings of guilt related to self-perceptions of excessive or irrational expressions of anger and responsibility for the trauma or injury causing the disability. Finally, *acceptance* or *adaptation* may encompass a myriad of behaviors ranging from "optimal, positive self-actualizing, to negative, embittered retreat" (Lindemann, 1981).

Families of Disabled Persons

The advent of a chronic disability within a family has been discussed in much the same terms used to portray reactions to traumatic injury

(see Blacher, 1984; Harris, 1983). Illustrative are clinician's descriptions of the reactions of parents to the diagnosis of a visual disorder in their child. Responses often include shock, grief, disappointment, and depression (Catena, 1961; Froyd, 1973). Guilt and anger may also be experienced, usually as a result of unwarranted (and sometimes superstitious) feelings of responsibility for the impairment (Cohen, 1964). Lowenfeld (1971) and Lambert and West (1980) have commented on the frequent family denial of the existence of the disability. Although these parents have natural love for the child, they are unable to accept the reality of the impairment. And recognition and emphasis of the child's deficits and inadequacies adversely affects attachment and other aspects of the parent-child relationship (Lowenfeld, 1971).

Of more recent concern are preliminary findings showing that a disproportionate number of disabled children, particularly those with additional handicapping conditions, are at greater risk for physical abuse and family abandonment (see review by Ammerman, Van Hasselt, & Hersen, 1988). An initial investigation in this area by Gil (1970) indicated that 29% of 6,000 confirmed cases of child abuse had some form of developmental disability. In a study of the incidence and characteristics of maltreatment in psychiatrically hospitalized and multihandicapped children, Ammerman, Hersen, Van Hasselt, McGonigle, and Lubetsky (1988) found that 39% of the 150 child participants exhibited evidence of past and/or current maltreatment. Physical abuse was the most common form, occurring in 69% of the maltreated sample. This was followed by neglect (45%) and sexual abuse (36%). In addition, 52% of the maltreated children experienced more than one form of maltreatment (e.g., physical abuse and neglect).

While research in this field is at the nascent stage, etiological factors implicated in maltreatment of disabled children are: (1) child characteristics, such as chronic and pervasive behavioral disturbances (e.g., aggression, self-injury, screaming), severe disability, and unresponsiveness to parental attention or commands (Friedrich & Boriskin, 1976; Frodi, 1981), and (2) family variables, including inadequate coping and stress management, deficient child management skills, and insufficient social support networks (Ammerman, Van Hasselt, & Hersen, 1988; Kadushin & Martin, 1981; Murphy, 1982). Similar child and family factors also have been found to have causal significance in a family's decision to place their disabled children out of the home (Janicki, 1981; McDowell & Gabel, 1981; Sherman, 1988; Turnbull, Summers, & Brotherson, 1986).

Prevalence

As indicated in the May, 1984, issue of the *American Psychologist*, there is an increasing number of individuals with some form of developmental or physical disability. Recent surveys indicate that as many as 36 million people, or 14% of the population of the United States, have some form of disability (Bowe, 1980). This is consistent with a previous report by the 1976 United States Census Survey of Income and Education, which revealed a figure of 13.6%. Also, 46% of persons 65 years of age and over report a serious and disabling health impairment (DeJong & Lifchez, 1983). Further, there are indications that as many as 10% of children under the age of 21 are disabled (Gliedman & Roth, 1980). Moreover, as a result of improved prenatal care, better nutrition, decreased infant mortality rates due to advances in surgical and medical care, and more effective treatments for infant diseases, the number of disabled persons is expected to rise sharply over the next decade (Dibedenetto, 1976; Mulliken & Buckley, 1983).

Related to the growing population of persons with a disability are the high economic costs of habilitative and rehabilitative programs (e.g., Goldenson, Dunham, & Dunham, 1978). For example, in 1977, disability-related payments to working-age individuals amounted to almost \$63.5 billion. Social Security Insurance and Supplemental Security Income programs alone paid \$20.6 billion to more than four million working-age people with disabilities in 1980 (DeJong & Lifchez, 1983).

Legal and Legislative Initiatives

Sweeping changes in the law and federal funding began with President John F. Kennedy's President's Panel on Mental Retardation, established in 1962. The efforts of the panel resulted in the enactment of Public Laws (P.L.) 88-164 and 88-156, which authorized the funding of research centers for the study of the causes, prevention, and treatment of developmental disabilities. Since that time, a number of funding agencies, especially those under the aegis of the Department of Education (e.g., National Institute on Disabilities and Rehabilitation Research, Office of Special Education Programs, Handicapped Children's Early Education Program) have provided substantial fiscal support for field-initiated research, model demonstration projects, professional training, and research centers directed toward disabled persons.