In the years since the first edition of this book, important developments have taken place in the rehabilitation field. Major advances have occurred on medical and technological fronts, and landmark legislation has embodied some of the best ideas of modern rehabilitation. The past three decades witnessed a new affirmation of human and civil rights and a determination on the part of disadvantaged groups, including people with disabilities, to speak out and act on their own behalf.

But how much can we count on continued progress? Some years ago my reply was “Not very much. . . . To assert otherwise would be to invite apathy” (Wright, 1973, p. 357). The elimination of attitudinal and other barriers that deny access to opportunities in the general life of the community is a mandate of basic human rights, but human rights are fragile insofar as they are subject to the vicissitudes of broad, sweeping social, economic, and political circumstances.

The title of the original edition, Physical disability—A Psychological approach, has been slightly altered in the present revision.
The phrase “a psychosocial approach” is preferred because the book examines problems in terms of the individual in relation to the social environment. Concepts discussed in the earlier edition are developed further, additional research is presented, and new problems and issues are addressed.

The volume strives to contribute knowledge and understanding that will lead to constructive views of life with a disability. Technical language has been kept to a minimum in the hope that readers of varying backgrounds, including students and professionals, individuals who have a disability, and the concerned general public will find the book as a whole, or sections therein, of value.

The following discussion makes explicit those “value-laden beliefs and principles” that have guided my work in rehabilitation as a field of study and service (Wright, 1972).¹ They are offered as possible guidelines with the intent that they be examined and improved, then kept in the forefront to remind and to prompt, to check and to challenge, lest they remain inactivated and submerged by the weight of social, political, and personal pressures of all sorts.

1. Every individual needs respect and encouragement; the presence of a disability, no matter how severe, does not alter these fundamental rights.

A person is entitled to the enrichment of life and the development of his or her abilities, whether these be great or small and whether the person has a long or short time to live. The person must not be led to devaluate the self or to give up hope. The person is not to remain neglected and deprived. Under no circumstance is the person to be treated as an “object” or “vegetable.”

Biases that declare some groups to be more worthy or deserving of services than others lead to gross inequities and must be avoided. Life, increased mobility, and better communication skills are as important to a 72-year-old as to a 12-year-old, to a mentally retarded person as to an average person, to a black person as to a white person, to a poor person as to a rich person.

The affirmation of human worth and dignity must not only be kept explicitly in the forefront when allocating limited resources but should also be reflected in adequate case-finding efforts so that no person who has a disability remains neglected.

2. The severity of a handicap can be increased or diminished by environmental conditions.

Although grammatical usage speaks of a “person’s handicap,” how handicapping a disability is depends to a great extent upon the characteristics of the person’s environment. Thus, physical handi-

¹Revised from the original 1972 version.
caps can be reduced by eliminating architectural barriers, interpersonal handicaps by overcoming devaluing social attitudes, educational handicaps by providing educational and training facilities, economic handicaps by extending work opportunities, and emotional handicaps by enhancing family and group support.

It should be stressed that the rehabilitation process itself carries an important environmental impact. Professionals and others must continuously question whether present methods or systems of operation are always or maximally helpful. They should seek ways to improve the rehabilitation process, as well as support environmental changes in the home and community that reduce the severity of handicapping conditions.

3. *Issues of coping and adjusting to a disability cannot be validly considered without examining reality problems in the social and physical environment.*

It is to be stressed that the personal-affective life of the individual generally can be most effectively strengthened within the context of dealing with reality problems that exist in the social and physical environment, rather than by treating feelings in an environmental vacuum. Supportive attitudes of family, friends, and professionals, as well as opportunities for satisfactory living offered by the community, facilitate the person’s efforts to come to terms with the disability.

4. *The assets of the person must receive considerable attention in the rehabilitation effort.*

A person’s healthy physical and mental attributes can become a basis for alleviating difficulties as well as providing a source of gratification and enrichment of life. Special care must be taken to avoid overemphasis on the pathologic that leaves one inadequately sensitized to stabilizing and maturity-inducing factors. Those attributes of the person that are healthy and promising must be supported and developed.

5. *The significance of a disability is affected by the person’s feelings about the self and his or her situation.*

Feelings that often have to be worked through by a person who has incurred a disability are those of resentment, inferiority, guilt, loneliness, and being a burden; doubts about whether he or she will still be loved and accepted; worries about the future and how one will manage; and concern that one will be left behind. Such social-emotional concerns take time to resolve. When the person accepts the disability as personally nondevaluating and engages life positively, important rehabilitation goals have been reached.

6. *The active participation of the client in the planning and execution of the rehabilitation program is to be sought as fully as possible.*
Genuine respect for the client leads to the affirmation of the right, within very broad limits, to become actively engaged in the rehabilitation process and to make decisions that affect one’s life. The client obviously also has information and ideas essential to rehabilitation progress that are not available to others.

Among the foremost consequences of active involvement on one’s own behalf are the enhancing of the person’s self-respect, initiative, and responsibility for carrying out decisions.

This principle requires that effort be made to determine the views of every client. Special effort will be necessary in those instances where a major problem of communication exists; for example, deafness, aphasia, cerebral palsy, mental retardation, foreign speech, ghetto speech, and stuttering.

7. The client is seen not as an isolated individual but as part of a larger group that includes other people, often the family.

The problems of the client are intimately connected with those of the larger group of people whose welfare is shared. Therefore, early and active participation of such significant others as spouses, parents, siblings, and children is viewed as an important principle in the total rehabilitation process. Where the client is in fact alone, or is resistant toward including other people, this principle may remain inactivated.

8. Because each person has unique characteristics and each situation its own properties, variability is required in rehabilitation plans.

Grouping persons according to a specific disability must not lead to stereotyped inferences about them. Differences in the needs, abilities, and circumstances of persons with the same or a similar disability require diverse approaches rather than the inflexible application of procedures.

Differences in problems that stem from particular characteristics of particular groups further serve to underscore the need for variability in the process of rehabilitation.

9. Predictor variables, based on group outcomes in rehabilitation, should be applied with caution to the individual case.

At the present stage of knowledge the individual, if given a chance, often becomes the exception which, instead of proving the rule, challenges it. Assessment data, therefore, generally can be used more appropriately as an indication of present status and as a guide to remediation than as a prognosticator of future performance.

The direct application of group-based predictor variables is not questioned in regard to the behavior of groups qua groups, as in voting or consumer behavior, but is questioned in regard to long-range decisions about a particular individual. Moreover, prediction based
on the response of the individual to the rehabilitation process, rather than on "group variables," encourages treatment corrections in accordance with continuing evaluation. The job in rehabilitation is to strive to establish the conditions under which the individual can "beat the odds."

10. **All phases of rehabilitation have psychological aspects.**

All human beings react cognitively and emotionally to events that involve them. These reactions in turn affect the further course of those events. One is compelled, therefore, to recognize that psychological factors are ever-present and often crucial in all aspects of rehabilitation—medical, surgical, educational, social, vocational, as well as primarily psychological.

The psychologist (as well as other psychosocially versed professionals) can offer help to other professions. For example, psychologists are able to describe principles and procedures that help to motivate a client, review body-mind relationships that are important in rehabilitation, assess client attributes, evaluate psychological and behavioral consequences of particular environmental situations, demonstrate ways to resolve intragroup and intergroup conflicts, and sensitize personnel to social-emotional aspects of professional-client relations.

11. **Interdisciplinary and interagency collaboration and coordination of services are essential.**

The needs of individual clients are so diverse, encompassing all problems that one might expect to encounter in human affairs, that a variety of services is necessary. Comprehensive rehabilitation, therefore, requires the effort of many professions and close working relations among the various kinds of rehabilitation agencies.

There is the persistent danger that the pressure to meet agency and professional needs most efficiently and conveniently will become the principal basis for coordinating services. To guard against this danger a clear and explicit focus on most effectively meeting client needs is required.

Because of the complexities in the system of services, the client needs a specified person to serve as "coordinator" or "advocate" in providing information and otherwise acting on his or her behalf. Such a person may come from a self-help group or any of the helping disciplines as appropriate, rather than routinely from a single profession.

12. **Self-help organizations are important allies in the rehabilitation effort.**

Self-help groups provide important programs and mutual support to their members. They also can aid rehabilitation personnel in the understanding of significant problems and the development of new directions in the rehabilitation field. More extensive collabora-
tion between professionals and self-help groups can be expected to further shared objectives.

13. In addition to the special problems of particular groups, rehabilitation clients commonly share certain problems by virtue of their disadvantaged and devalued position.

Devaluation and disadvantage are general life problems experienced by diverse groups: persons who have a physical, mental, or emotional disability; racial and religious minority groups; the poor; and so on. These common problems give rise to important rehabilitation goals that are shared among socially and economically deprived groups.

Special problems stemming from the particular characteristics of particular groups are locomotion difficulties of persons with orthopedic disabilities, communication problems of those who have impaired hearing, addiction in the case of the drug user, malnutrition of the poor, intellectual deficits of the mentally retarded, and so on.

14. It is essential that society as a whole continuously and persistently strives to provide the basic means toward the fulfillment of the lives of all its inhabitants, including those with disabilities.

Among the obligations of society are the establishment of needed housing, schools, work opportunities, transportation, hospitals, recreation facilities, and other services. Professionals and others bear a responsibility in helping to meet these obligations by initiating and supporting appropriate legislation and programs.

Where national and community resources are limited, ways to make more effective use of them or to expand them must be sought. Inertia and resistance to change lead to ignoring pressing problems and must be replaced by a determined effort to work toward better solutions.

Extending the goals of rehabilitation to their ultimate implications requires that effort be directed toward the prevention of handicapping conditions. Improvement of health care, reduction of accidents, control of pollution, overcoming of prejudice, diminution of poverty, are all major societal responsibilities. Professionals and the general public cannot remain indifferent to them.

15. Involvement of the client with the general life of the community is a fundamental principle guiding decisions concerning living arrangements and the use of resources.

Under special circumstances, where vital considerations indicate the advisability of some form of institutional living, every effort should be made to help the resident participate in community activities and services. Involvement with the community can also be served by sharing institutional resources and activities with the public. Periodic visits on the part of the resident with family, friends, or in foster homes, should become established procedure. The location
of institutions within, rather than outside, communities facilitates such integration.

The development of halfway houses and other interim steps that encourage community involvement is imperative. Housing designed to meet special needs should be available in the community to persons with disabilities.

The client who chooses specialized living arrangements should continue to have the option and opportunity to move elsewhere as circumstances permit. In the interest of life enrichment, the space of free movement of a person should be enlarged rather than restricted.

16. **People with disabilities, like all citizens, are entitled to participate in and contribute to the general life of the community.**

Persons who have a disability should not only fulfill the role of consumers. They also have abilities and talents that offer a significant resource that should be utilized for the betterment of the community. The removal of attitudinal and environmental barriers that prevent full participation in community life must be pursued on many fronts, including research, public education, legislation, and other forms of action.

17. **Provision must be made for the effective dissemination of information concerning legislation and community offerings of potential benefit to persons with disabilities.**

Large numbers of persons with disabilities remain unaware of available services from which they could benefit. Professionals are also often unaware of them and thus do not serve adequately as sources for information and referral. Solution of the problem requires a variety of approaches by which both professionals and clients can be kept abreast of opportunities that might be of benefit.

18. **Basic research can profitably be guided by the question of usefulness in ameliorating problems, a vital consideration in rehabilitation fields, including psychology.**

Basic research can be useful research in the sense of being oriented toward the alleviation and overcoming of problems faced in rehabilitation. The converse is also true: useful research can be basic research in the sense of advancing knowledge through the discovery of general principles that apply beyond the borders of the immediate situation. It is misleading and stultifying to identify basic research with "pure" research, the unwitting assumption being that any guide to research other than that given by "knowledge for its own sake" renders it impure and somehow less basic.

It is, therefore, urged that the question of usefulness be regarded with favor as a guide to research. Basic research can profitably become real-life oriented in its conception and from its inception by considering usefulness as a value in the selection of problems, analy-
sis of data, communication of results, and application of findings. In bridging the gap between theory and research, psychological concepts need to be examined and new ones introduced in the light of their usefulness in dealing with everyday life problems of persons who have a disability.

19. **Persons with disabilities should be called upon to serve as co-planners, coevaluators, and consultants to others, including professional persons.**

   It is important that the rehabilitation field take advantage of the special knowledge and viewpoints of people who have a disability. Such persons have had first-hand experience with the rehabilitation process and are directly involved with problems that personally affect them. Their ideas should be especially sought concerning ways in which rehabilitation services can be improved and the lives of people with disabilities enriched.

   Organizations on behalf of persons who have a disability should make it a point to include representatives of client groups on their advisory boards. Examples of such organizations are rehabilitation centers, private and governmental health agencies, foundations, schools, and hospitals. Rehabilitation agencies should make certain that persons with disabilities serve in professional and nonprofessional capacities.

   With respect to research on problems of rehabilitation, the special sensitivities and understandings of persons who have a disability can be utilized by having them serve as consultants and coinvestigators.

20. **Continuing review of the contributions of psychologists and others in rehabilitation within a framework of guiding principles that are themselves subject to review is an essential part of the self-correcting effort of science and the professions.**

   The values and beliefs expressed in the foregoing set of principles need to be periodically reviewed for two main reasons. First, change in emphasis and content may be indicated by new knowledge and changing times. Second, specification as to how the principles can best be implemented requires constant examination and study if their effectiveness as guides in rehabilitation is to be increased.

   In many cases, the sheer process of seriously examining a principle will reveal instances in which it is not reflected in actual practice as well as ways to improve the situation. Serious examination is directly available to everyone and when carried out in brainstorming group sessions can be especially productive.

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