JOURNAL OF DISABILITY STUDIES

Positive Approaches to Overcoming the Stigma of Disability

Noel A. Ysasi[1*], Roy K. Chen[2], Megan E. Jones[3]

1 Northern Illinois University, USA. 2 University of Texas Rio Grande Valley, USA. 3 University of Kentucky, USA.

ABSTRACT

People with disabilities often face prejudice and discrimination because of their physical and/or mental deviance from norms subjectively defined by society. The stigma associated with having a disability can have a negative impact on the quality of life of this population. The purpose of this paper is to discuss theory-based strategies and approaches that people with disabilities can adapt to overcome and mitigate the adverse effects of a stigmatizing disability. Specifically, the paper uses the hope theory and positive psychology theory as foundations to pave way for weaving spiritual well-being, resilience, and optimism into psychoeducation efforts to help people with disabilities reconstruct their schemas toward the self-acceptance of disability and the empowerment of their rights to advocate for full integration in society.

Keywords: Positive psychology, resilience, stigma, disability

INTRODUCTION

Historically, the attitudes toward and treatment of people with disabilities (PWDs) have been negative and often create societal barriers (e.g., discrimination)affecting the overall quality of life. Despite continuous efforts to reduce the level of stigma frequently associated with having a disability, discrimination and prejudice remain. In general, stigma is a social construction based on individual and group differences resulting in the devaluing of persons who possess varying qualities (Coleman, 1997; Dovidio, Major, & Crocker, 2000; Smart, 2016). Consequently, society's attitudes and behaviors can dramatically impact individuals well after any actual interaction has occurred (Goffman, 1963; Laing, 1965; Szasz, 1961). For example, veterans often face challenges in overcoming the stigma associated with having served in the military and being labeled with a disability (e.g., post-traumatic stress disorder), particularly during job interviews. Or consider a parent who does not disclose his or her child's disability to school administration due to fear of labeling, exclusion from class instruction, and bullying. A counseling professional may experience apprehension from a client in discussing his or her disability and/or become stuck in the "denial" psychosocial (e.g.People with disabilities are seen as inferior and weak, and I am not weak, therefore I do not have a disability). All of these possible reactions can affect an individual's employability, adjustment, acquisition of disability accommodations, counseling services, and overall quality of life.

Positive attitudes and acceptance of others can have a profound impact on self-perception, autonomy, and adjustment, whereas stigmas associated with a disability can have the opposite effect (Phemister & Crewe, 2012). Consider the importance of autonomy, the self-perception of mastery over the environment (e.g., successful employment outcomes due to strengths regardless of having a disability) and the ability to have control over situations (Marini & Stebnicki, 2012). Nonetheless, PWDs often struggle with living an autonomous life due to societal barriers, employment discrimination direct against PWDs, and a lack of available resources(Marini & Stebnicki, 2012). As a case in point, the first author's father is blind and has a master's degree in social work. Yet, despite his qualifications, he often found difficulty obtaining full-time employment because of misperceptions commonly associated with having a disability. Specifically, a frequently asked question during interviews involved, "How can you counsel clients if you can't see them?" For the rehabilitation counselor, how does one effectively work with PWDs towards developing and/or maintaining positive approaches to overcoming stigma when individuals generally encounter employment/societal barriers? Therefore, the purpose of this paper is to discuss some commonly occurring adaptation difficulties encountered by PWDs and methods for assisting clients in the therapeutic setting for establishing a healthy approach to overcoming societal stigma.

*Corresponding Author
Email:nysasi@niu.edu

DISABILITY AND ADAPTATION

Understanding the demographic characteristics of PWDs is crucial in establishing a successful and therapeutic relationship. As a vast amount of research has made evident, it is not uncommon for persons with mental health disorders and people with physical disabilities to experience comorbid adjustment difficulties because of their disability. For instance, various dual-diagnosis attributes are often found (whether short-term or long-term) among persons with physical disabilities (i.e., person with multiple sclerosis becoming clinically depressed), as well as mental health disorders (i.e. person with Tourette's syndrome also having social anxiety disorder). For example, approximately 66% of individuals who have sustained a traumatic disabling condition (e.g., traumatic brain injury) have met the diagnostic criteria for a substance abuse disorder (Heinemann, 1993). When considering mental health, depression continues to be a leading cause of disability among persons aged 15 to 44 (Kessler, Chiu, Demler, & Walters, 2005). Turner and McLean (1989) reported people with physical disabilities were three to four times more likely than those without to meet the diagnostic criteria for major depression. A consideration when working with clients who do present symptoms of depression is assessing for suicidal ideation.

It should be noted, however, that not all individuals experience depression, substance abuse disorder, drug use disorder, or any comorbid condition as a result of their primary disability. Various predisposing factors are often the result of a higher incidence rate for the aforementioned co-occurring conditions and for how well a person may effectively overcome adversity. For example, ethnicity, gender, age, activities of daily living, socioeconomic status, the severity of a disability, perceived quality of life, subjective well-being, stigma, self-esteem, and emotional support are all potential contributors towards how a person adapts to a disability. As a result, two individuals with the same disability may adjust very differently, often depending upon the abovementioned underlying factors.

However, the question arises: How do stigma and disability correlate with one another? Through the process of adjusting to a disability, individuals may struggle with integrating into society, as a result, of perceived discrimination. For instance, people with cognitive and physical disabilities are often exposed to stigma in comparison to the "average" person, which, in turn, frequently impacts the development of these individuals' identify and self-respect (Schanke&Thorsen, 2014). Essential to the issue of societal acceptance of disabilities is the manner in which PWDs are able or not to accept their own disability (Chen, Kotbungkair, & Brown, 2015; Li & Moore, 1998). According to the labeling perspective, self-perception can often be affected once an individual becomes cognizant of his or her stigmatized label (Li & Moore, 1998). Thus, how an individual accepts or rejects social labeling becomes highly relevant and important to understanding self-reaction. As a case in point, PWDs who experience levels of societal discrimination and/or stigma may resort to substance abuse in an effort to escape or become emotionally disconnected (Walker, Cole, Logan, & Corrigan, 2007). However, those who reject the stigmatizing label have been shown to produce higher levels of self-esteem and adjustment to a disability (Warner, Taylor, Powers, & Hyman, 1989).

OVERCOMING DISABILITY RELATED STIGMA

Up to this point, the paper has primarily focused on stigma and the exploration of adjustment to disability while factoring in comorbid conditions that often arise. As previously noted, not all individuals will become depressed, resort to illicit drug use, or, for that matter, demonstrate any level of maladaptive behavior when adjusting to a disability; likewise, not all PWDs are able to overcome adversity, excel, and transcend(Marini &Stebnicki, 2012). The remainder of this paper will explore positive psychology and some of its tenets (hope theory, subjective well-being, resilience, and optimism) in relation to working with PWDs with the purpose of overcoming the stigmatizing effects of disability.

POSITIVE PSYCHOLOGY

The ability to transcend through adversity has been of significant interest among researchers and mental health professionals. Positive psychology has been described as the study of optimal experience, acknowledging the low points that transpire in life, and stressing the importance of recognizing the positive outcomes that often occur but are frequently overlooked (Peterson & Park, 2015). Seligman and Csikszentmihalyi (2000) outline the three parts of positive psychology: (a) subjective experiences–happiness, well-being, hope, and optimism, (b) individual traits–the ability to forgive, persevere, and achieve a certain level of interpersonal skills, and (c) group level–institutions (e.g., communities, businesses) that support, nurture, encourage, and accept responsibility. Rather than fixating on the pathology of human functioning, positive psychology has been a catalyst for change in the field of psychology by focusing on the positive qualities that each person possesses (Seligman & Csikszentmihalyi, 2000). Nevertheless, if one of the three parts of positive psychology is absent, the difficulties in overcoming stigma related to having a disability increase.

Considered highly influential for this theoretical framework, Beatrice Wright (1983) believed that environmental/group factors (i.e., societal stigma) can influence the quality of life, whether one can fully accept a disability, and facilitate a handicap. She further emphasized that positive outcomes are often experienced when an individual is faced with adversity (Livneh & Martz, 2016) and believed in the importance of focusing on the assets and personal traits one possesses (Wright, 1983). Stemming from an optimistic yet pragmatic approach, she delineated the idea of coping with versus succumbing to a disability (McCarthy, 2011). Specifically, when a person succumbs to a disability, they are unable to move forward in a positive direction, but rather, give in, often resulting in low self-esteem, substance abuse, identify failure and having a negative,

devalued outlook on life (Beck & Lustig, 1990; Livneh & Martz, 2016; Wright, 1983). However, the idea of "coping" can be seen within the framework of positive psychology in which the coping individual is able to overcome challenges, is primarily focused on achieving his or her goals, has higher problem-solving abilities, and adopts the internal locus of control concept, thereby increasing overall life satisfaction (Livneh & Martz, 2016). For the counselor, one should focus on the client's available resources and strengths and rather than becoming fixated on what the client doesn't have in relation to those without a disability should look at the similarities (McCarthy, 2011).

Hope Theory: Throughout history, researchers and clinicians have focused on identifying and preventing psychopathology (Valle, Huebner, & Suldo, 2006). However, the installation of hope among mental health practitioners when working with PWDs can be central to encouraging a positive psychological and physical adjustment to one's disability. As a tenet of positive psychology, hope theory has been described as a "system of goal-attainment behavior characterized by the agency (will) and pathways (way) thinking" (Watson, Hayes, Radford-Paz, & Coons, 2013, p. 78). Adding to this concept, Snyder (2000) identified three major components of hope theory and elaborated on each. They include (a) *goals*: targets of mental actions that are either short-term or long-term, but must be of sufficient value to be effective; (b) *pathways thoughts*: the ability to imagine the route in which a person will initiate the goal and reach the desired endpoint; and (c) *agency thoughts*: the motivational factor that leads people along their imagined routes (p. 13). When clients have multiple routes to achieving their desired endpoint, elevated levels of hope can be seen(Valle et al., 2006). For further consideration, individuals who are affected by stigma due to disability can use the concepts of goals, pathways, and agency thoughts, to overcome obstacles and achieve desired goals.

When considering the value of this theory to overcoming stigma, it should be noted that persons who have higher levels of hope experience elevated perceptions of self-worth, increased social desirability, and favorable outlooks toward the future (Snyder et al., 1991; Snyder, McDermott, Cook, & Rapoff, 1997). However, a person can lose his or her previous aspiration toward life goals if he or she has sustained a traumatic experience (e.g., war, car crash); thus, a counselor should make every attempt to instill hope by removing intrusive thoughts so that hope may flourish once again (Snyder, 2000). Moreover, the research behind the installation of this theory within the rehabilitation counseling process has revealed that people with increased levels of hope tend to have higher goals, perceive their goals as challenges, are less lonely, have socially desirable skills, are generally happier, and have improved levels of adjustment to disability in comparison to those with lower levels of hope (Synder, 1995).

Subjective Well-Being (SWB): Despite the adversities PWDs encounter, how is it that so many are able to adjust to a disability and counter discrimination, prejudice, and other life adversities? Some considerations are a person's subjective well-being, resilience, and levels of optimism. Subjective well-being has been described as a normally positive state of mind in which one effectively evaluates his or her life and assesses the moment-to-moment and day-to-day conditions (Diener, Lucas, & Oishi, 2009). The implications of SWB for psychological health have been profound. Norman Bradburn (1969) was revolutionary in this concept; he discovered that the attempts of practitioners of psychology to eliminate negative states are not necessarily effective in creating positive states."Ridding the world of pain may not result in a corresponding increase in pleasure; ridding the world of sadness and anxiety will not necessarily make it a happier place" (Diener et al., 2009). The discipline has grown significantly within a relatively short period of time and Diener et al. (2009) provide explanations as to why. First, as the abundance of materialistic goods has grown exponentially, the overwhelming need to possess materialistic items no longer holds the same power to satisfy as it once did. Rather, it is the quality of life that has gained popularity and is of more pressing concern, not economic prosperity. Secondly, SBW is democratic in nature; we are allowed the individualistic freedom to delineate what constitutes a "good life" and not society. For example, despite a person being within a lower socioeconomic bracket, many with SWB will consider having a job, a home, and family to love, as to what constitutes "happiness." When considering PWDs, the benefit of SBW can be of significant value. As having a disability is often accompanied by societal stigma, the disruption inflicted on quality of life often seen through prejudice and discrimination would normally not be a factor, as is stressed through this theoretical model. Thirdly, as the trend has shifted considerably in the direction of individualism around the world, researching SWB and its impact has been a growing trend. Human beings are inherently concerned with their own feelings and beliefs; thus, the study of SWB has become a growing trend that accords well with Western philosophy.

To bring to light SWB within a counseling perspective, consider a PWD who continuously experiences unemployment regardless of having strong interviewing skills and pre-injury work-experience. Rather than placing blame and/or becoming fixated on the environmental factors that may have contributed to unsuccessful employment outcomes, a person with SWB will focus on their accomplishments and seek positive alternatives (i.e., seeking employment services through a vocational rehabilitation counseling agency). Alternatively, when trying to elevate a person's SBW, Fordyce (1977, 1983) established a framework for boosting happiness. This involves learning to imitate the positive behavioral traits of happy people (e.g., providing a client with homework in identifying PWDs that have been successful and are happy), developing organization skills, staying busy, establishing a positive outlook, and having a healthy attitude (Fordyce, 1983). Incorporating these methods can prove useful in increasing levels of SWB while simultaneously countering the negative effects of stigma.

Resilience: Rehabilitation settings rarely focus on the repercussions individuals with disabilities face related to stigma; however, an optimal approach to working with clients who encounter the struggles of daily stigma, is the use of resilience as a coping strategy (Schanke&Thorsen, 2014). Persons with higher levels of resilience are more likely to thrive regardless of life circumstances (Breitkreuz, Wunderli, Savage, & McConnell, 2014); unfortunately, members of the rehabilitation professions continue to fail to make efforts to continue to fail to make efforts to increase resiliency among PWDs (Luthar, Cicchetti, & Becker, 2000). Resilience has been characterized as the ability to maintain good outcomes in spite of overwhelming challenges and difficult circumstances. More specifically, it is the practical way in which people respond to these stressors, often a result of positive personal qualities possessed by extraordinary people (Runswick-Cole &Goodley, 2013). The resilience model has been viewed as having three distinct perspectives, which consist of the following: (a) a pattern of competent behaviors adopted through stressors within one's environment; (b) a process by which individuals are able to modify the impact of overwhelming challenges and thus adapt successfully; and (c) an ability to the interact between the spectrum of risks and protective factors amid unfavorable conditions (Olsson, Bond, Burns, Vella-Brodrick, & Sawyer, 2003). Overall, it consists of the problem-solving skills, attitude, self-efficacy, self-esteem and ability to connect within one's environment and seek out community resources, develop social networks, and to overcome situational factors, which facilitate higher levels of resiliency (Thompson, 2002). Situational factors can be explained as the type of disability acquired and functional limitations, and how these limitations are perceived by the individual. Nevertheless, resilience is often only associated with personality traits and not considered a skill that can be learned (White, Driver, & Warren, 2008). As a result, attempts at promoting awareness of how to enhance resiliency have started to gain attention as is discussed below.

Attempting to develop and/or increase levels of resiliency first require the assessment of where a person stands on his or her current resiliency state (Richardson, 2002). So, for example, individuals with high resiliency skills often demonstrate behavioral characteristics that strongly coincide with levels of perceived competence, extroversion, and openness. Conversely, lower resiliency skills are often seen among clients who consistently fail to maintain or keep appointments or show frequent levels of aggression, isolation, and substance abuse (White et al., 2008). Once rapport and trust have been established, implementing a resiliency-based therapy can be initiated; often educational in nature, the counselor explains how a person's maladaptive behavior is preventing him or her from progressing (Richardson, 2002). Common approaches to this form of therapy include the following: facilitating the access to material resources, building positive relationships, providing assistance in gaining purpose and identity, encouraging the power and control of one's thoughts and actions, engaging in positive self-talk during therapy sessions through the methods of role-play, encouraging positive thinking, providing assistance for the development of positive social skills, and advocating for finding a meaningful role in society (Runswick-Cole & Goodley, 2013).

Optimism: Optimism, however, is the ability to see the good outcomes in life rather than obsessing over the bad. Research has consistently revealed that optimistic attributes lead to successful adaptation to a disability and decreased levels of depression and psychological distress and are a strong predictor for life-satisfaction and overall well-being (Bonney & Stickley, 2008; Ferguson & Goodwin, 2010; Puskar, Sereika, Lamb, Tusaie-Mumford, & McGuinness, 1999; Steptoe, O'Donnell, Marmot & Wardle, 2008). Although having optimistic attributes may seemingly be a "no-brainer," every person carries distinct temperaments that separate him or her from the rest of society. These temperaments may have been facilitated through nature (genetic predisposition), nurture (environmental), or both. As a result, it may be difficult for some to view life positively when a person's innate characteristic is of a naturally pessimistic quality or because of the societal factors that have consistently shaped the individual's personality. Regardless of whether a person's natural tendency is to be optimistic or pessimistic, the rehabilitation counseling professional should identify when a behavior is counterproductive and confront the client. As an illustration, the rehabilitation counselor explains how adopting or maintaining an optimistic outlook can be crucial to overall success, create a client and practitioner alliance, and assist with obtaining gainful employment. Such a simple concept, yet the chances against surmounting such odds have always been against PWDs. Accordingly, how we perceive ourselves, see the positive in life despite hardships, and reject stigma are necessary attributes towards improving the unfavorable views of society and progressing toward the pinnacle of life satisfaction. Furthermore, as the social stigma associated with PWDs has been shown to impact a person's development and decrease perceptions of self-respect, it is necessary for the rehabilitation counseling process to incorporate a resilience strength-based approach to aiding a client adjust to his or her feelings, counter negative thoughts and behaviors affecting self-worth and provide guidance on the various methods for responding to the stigmatizing effects from others (Schanke & Thorsen, 2014).

When working with clients who are consistently fixated on the resistance found within their environment, one should reject the idea of focusing on the negative effects of stigma (Garmzey & Masten, 1990), but rather, stress the importance of tuning into the aforementioned approaches that will, in turn, assist PWDs to overcome stigma. Although the resiliency model and the incorporation of promoting optimism has been considered complex among novice professionals, if well-implemented, the reversal of negative impressions and thoughts tied to stigma can shift and aid the client in attaining optimum life experiences (Garmezy, Masten, & Tellegan, 1984; Ouellette-Kuntz et al., 2014; Wong, Fong, & Lam, 2015).

ADDITIONAL APPROACHES TO OVERCOMING STIGMA

Spirituality

Over the past decade, spirituality and religion have gained considerable attention and continues to be an emerging modality throughout rehabilitation and interdisciplinary practices (Lindgren & Coursey, 1995). Correlational research on its effectiveness among PWDs has revealed spirituality and religion promotes healthy well-being, psychological adjustment to disabilities, and can give meaning and purpose to life (Glover-Graf, Marini, Baker, & Buck, 2007). In a study conducted by Jonker and Greeff (2009), findings indicated spirituality and religion aided in overcoming stress and operated as a coping mechanism for PWDs and their families. However, in spite of the empirical support of religion and spirituality, it does not always bring about optimism and hope for all PWDs who believe in a higher power. For example, some individuals with a disability become angry with God, perceive their impairment(s) as a punishment from God, and/or resent God for acquiring their disability (Glover-Graf et al., 2007).

Psychoeducation

Although positive psychology, subjective well-being, hope theory, resilience, and optimism have often been viewed as valuable methods and attributes towards overcoming stigma, additional considerations towards working with PWDs can prove useful. For instance, during the rehabilitation counseling process, applying psychoeducation (a teaching method) for educating a client about their disability through discussing the functional limitations, incidence of their disability among the general population, and frequently perceived misconceptions of disabilities, can prove useful with increasing coping skills, and enhancing overall well-being, and empowering consumers. Though psychoeducation is normally a clinically-based practice, it is a valuable technique that can be applied throughout multiple rehabilitation settings (i.e., vocational rehabilitation).

CONCLUSION

Rehabilitation professionals often struggle with assisting consumers towards mutually agreed upon goals (i.e., successful employment outcomes) as clients are often combatting the challenges of negative self-worth stemming from societal stigmas repeatedly encountered. Although it is undeniable that person-environmental factors interact with the approaches offered in this paper for overcoming stigma, fixating on external forces rather than the intended outcome is counterproductive (Warren, Van Eck, Townley, & Kloos, 2015). Furthermore, as the rehabilitation practice continues to be filled with passionate and dedicated professionals promoted to supporting independence, elevating subjective well-being, and eradicating discrimination, and prejudice, the need towards providing positive approaches to overcoming stigma is necessary for acceptance and overall well-being. As a result, individuals working with PWDs should assist clients in recognizing their personal attributes in an effort to empower, self-advocate, and reject the negative perceptions of others.

REFERENCES

Beck, R. J., & Lustig, P. (1990). Counseling the chronic pain patient. In T. W. Miller (Ed.), *Chronic pain* (pp. 725-755). Madison, CT: International Universities Press, Inc.

Bonney, S., & Stickley, T. (2008). Recovery and mental health: A review of the British Literature. *Journal of Psychiatric & Mental Health Nursing*, *15*(2), 140-153. doi:10.1111/j.1365-2850.2007.01185.x

Bradburn, N. M. (1969). *The structure of psychological well-being*. Oxford, UK: Aldine.

Breitkreuz, R., Wunderli, L., Savage, A., & McConnell, D. (2014).Rethinking resilience in families of children with disabilities: A socioecological approach. *Community, Work & Family*, *17*(3), 346-365. doi:10.1080/13668803.2014.893228

Chen, R. K., Kotbungkair, W., & Brown, A. D. (2015).A comparison of self-acceptance of disability between Thai Buddhists and American Christians.*Journal of Rehabilitation*, *81*(1), 52-62.

Coleman, L. (1997). Stigma: An enigma demystified. In L. Davis (Ed.), *The disability studies reader* (pp. 216-230). New York, NY: Rutledge.

Diener, E., Lucas, R. E., & Scollon, C. N. (2009). Beyond the hedonic treadmill: Revising the adaptation theory of well-being. In E. Diener (Ed.), *The science of well-being: The collected works of Ed Diener* (pp. 103-118). New York, NY: Springer Publishing Company.

Diener, E., Oishi, S., & Lucas, R. E. (2009). Subjective well-being: The science of happiness and life satisfaction. In S. J. Lopez &C. R. Snyder (Eds.), *Oxford handbook of positive psychology* (2nd ed.) (pp. 187-194). New York, NY: Oxford University Press.

Dovidio, J., Major, B., & Crocker, J. (2000). Stigma: Introduction and overview. In T. Heatherton, R. Kleck, M. Hebl, & J. Hull (Eds.), *The social psychology of stigma* (pp. 153-183). New York, NY: The Guilford Press.

Ferguson, S. J., & Goodwin, A. D. (2010). Optimism and well-being in older adults: The mediating role of social support and perceived control. *International Journal of Aging and Human Development*, *71*(1), 43-68.

Fordyce, M. W. (1977). Development of a program to increase personal happiness. *Journal of Counseling Psychology*, *24*(6), 511-521.doi: 10.1037/0022-0167.24.6.511

Fordyce, M. W. (1983). A program to increase happiness: Further studies. *Journal of Counseling Psychology*, *30*(4), 483-498.doi: 10.1037/0022-0167.30.4.483

Garmezy, N. (1991). Resiliency and vulnerability to adverse developmental outcomes associated with poverty. *American Behavioral Scientist*, *34*(4), 416-430.

Garmezy, N. A., Masten, N., & Tellegan, A. (1984). The study of stress and competence in children: A building block for developmental psychopathology. *ChildDevelopment*, *55*(1), 97-111.

Glover-Graf, N. M., Marini, I., Baker, J., & Buck, T. (2007).Religious and spiritual beliefs and practices of persons with chronic pain. *Rehabilitation Counseling Bulletin*, *51*(1), 21-33.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. New York, NY: Simon and Schuster, Inc.

Heinemann, A. W. (1993). *Substance abuse and physical disability*. New York, NY: Haworth Press, Inc.

Jonker, L., & Greeff, A. P. (2009). Resilience factors in families living with people with mental illnesses. *Journal of Community Psychology*, *37*(7), 859-873.

Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-Month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 617-627. doi: 10.1001/archpsyc.62.6.617

Laing, R. D. (1965). *The divided self: An existential study in sanity and madness*. New York, NY: Penguin Books.

Li, L., & Moore, D. (1998).Acceptance of disability and its correlates. *Journal of Social Psychology, 138*(1), 13-25. doi: 10.1080/00224549809600349

Lindgren, K. N., & Coursey, R. D. (1995). Spirituality and serious mental illness: A two-part study. *Psychosocial Rehabilitation Journal, 18*(3), 93-111. doi: 10.1037/h0095498

Livneh, H., & Martz, E. (2016). Psychosocial adaptation to disability within the context of positive psychology: Philosophical aspects and historical roots. *Journal of Occupational Rehabilitation, 26*(1), 13-19.

Luthar, S. S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development, 71*(3), 543-562.

Marini, I., &Stebnicki, M. (2012).*The psychological and social impact of illness and disability* (6th ed.). New York: Springer Publishing Company.

McCarthy, H. (2011). A modest festschrift and insider perspective on Beatrice Wright's contributions to rehabilitation theory and practice. *Rehabilitation Counseling Bulletin, 54*(2), 67-81.doi: 10.1177/0034355210386971

Olsson, C., Bond, L., Burns, J., Vella-Brodrick, D., & Sawyer, S. (2003). Adolescent resilience: A concept analysis. *Journal of Adolescence, 26*(1), 1-11.

Ouellette-Kuntz, H., Blinkhorn, A., Rouette, J., Blinkhorn, M., Lunsky, Y., & Weiss, J. (2014). Family resilience: An important indicator when planning services for adults with intellectual and developmental disabilities. *Journal on Developmental Disabilities, 20*(2), 55-66.

Peterson, C., Park, N., & Sweeney, P. J. (2008). Group well-being: Morale from a positive psychology perspective. *Applied Psychology, 57*(1), 19-36.doi: 10.1111/j.1464-0597.2008.00352.x

Phemister, A. A., & Crewe, N. M., (2012). Objective self-awareness and stigma: Implications for persons with visible disabilities. In I. Marini & M. A. Stebnicki (Eds.), *The psychological and social impact of illness and disability* (6th ed.). New York, NY: Springer Publishing Company.

Puskar, K., Sereika, S., Lamb, J., Tusaie-Mumford, K., & McGuinness, T. (1999). Optimism and its relationship to depression, coping, anger, and life events in rural adolescents. *Issues in Mental Health Nursing, 20*(2), 115-130.

Richardson, G. E. (2002). The metatheory of resilience and resiliency. *Journal of Clinical Psychology, 58*(3), 307-321. doi: 10.1002/jclp.10020

Runswick-Cole, K., & Goodley, D. (2013). Resilience: A disability studies and community psychology approach. *Social & Personality Psychology Compass, 7*(2), 67-78. doi: 10.1111/spc3.12012

Seligman, M. P., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist, 55*(1), 5-14. doi: 10.1037/0003-066X.55.1.5

Schanke, A. K., & Thorsen, K. (2014). A life-course perspective on stigma-handling: Resilience in persons of restricted growth narrated in life histories. *Disability and Rehabilitation, 36*(17), 1464-1473. doi: 10.3109/09638288.2013.853842

Smart, J. (2016). *Disability, society, and the individual* (3rd ed.). Austin, TX: Pro-Ed.

Snyder, C. R. (1995). Conceptualizing, measuring, and nurturing hope. *Journal of Counseling & Development, 73*(3), 355-360. doi: 10.1002/j.1556-6676.1995.tb01764.x

Snyder, C. R. (2000). The past and possible futures of hope. *Journal of Social and Clinical Psychology, 19*(1), 11-28. doi: 10.1521/jscp.2000.19.1.11

Snyder, C. R., Harris, C., Anderson, J. R., Holleran, S. A., Irving, L. M., Sigmon, S. T., Yoshinobu, L., Gibb, J., Langelle, C., & Harney, P. (1991). The will and the ways: Development and validation of an individual-differences measure of hope. *Journal of Personality and Social Psychology, 60*(4), 570.doi: 10.1037/0022-3514.60.4.570

Snyder, C. R., McDermott, D., Cook, W., &Rapoff, M. A. (1997). Hope for the journey: Helping children through good times and bad. Boulder, CO: Westview.

Steptoe, A., O'Donnell, K., Marmot, M., & Wardle, J. (2008). Positive affect and psychosocial processes related to health. *British Journal of Psychology, 99*(2), 211-227. doi: 10.1348/000712607X218295

Szasz, T. (1961).*The myth of mental illness*. New York, NY: Dell.

Thompson, N. (2002). *Building the future: Social work with children, young people and their families*. Lyme Regis, UK: Russell House Publishing.

Turner, R. J.,& McLean, P. D. (1989).Physical disability and psychological distress.*Rehabilitation Psychology, 34*(4), 225-242. doi: 10.1037/h0091727

Valle, M. F., Huebner, E. S., & Suldo, S. M. (2006). An analysis of hope as a psychological strength. *Journal of School Psychology, 44*(5), 393-406. doi: 10.1016/j.jsp.2006.03.005

Walker, R., Cole, J. E., Logan, T. K., & Corrigan, J. D. (2007). Screening substance abuse treatment clients for traumatic brain injury: Prevalence and characteristics. *Journal of Head Trauma Rehabilitation, 22*(6), 360-367. doi: 10.1097/01.HTR.0000300231.90619.50

Warner, R., Taylor, D., Powers, M., & Hyman, J. (1989). Acceptance of the mental illness label by psychotic patients: effects on functioning. *American Journal of Orthopsychiatry, 59*(3), 398-409.

Warren, P., Van Eck, K., Townley, G., &Kloos, B. (2015).Relationships among religious coping, optimism, and outcomes for persons with psychiatric disabilities. *Psychology of Religion and Spirituality, 7*(2), 91-99. doi: 10.1037/a0038346

Watson, S., Hayes, S., Radford-Paz, E., & Coons, K. (2013). "I'm hoping, I'm hoping...": Thoughts about the future from families of children with autism or fetal alcohol spectrum disorder in Ontario. *Journal on Developmental Disabilities, 19*(3), 76-93.

White, B., Driver, S., & Warren, A. (2008).Considering resilience in the rehabilitation of people with traumatic disabilities. *Rehabilitation Psychology, 53*(1), 9-17. doi: 10.1037/0090-5550.53.1.9

Wong, P. K., Fong, K. W., & Lam, T. L. (2015).Enhancing the resilience of parents of adults with intellectual disabilities through volunteering: An exploratory study. *Journal of Policy and Practice in Intellectual Disabilities, 12*(1), 20-26. doi: 10.1111/jppi.12101

Wright, B. A. (1983). *Physical disability: A psychosocial approach* (2nd ed.). New York, NY: HarperCollins Publishers.