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Developing Positive Attitudes and Approaches When Working with Persons with Disabilities

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Abstract

More than ten percent of the population of North America have disabilities or chronic illnesses. Persons who acquire disabilities have many issues to face. Psychosocial adjustment can be difficult as they reconcile losses and explore strengths. Societal attitudes and policies create barriers to full functioning. Latter-day Saints with disabilities may face the additional challenge of reconciling spiritual beliefs with physical reality. This paper addresses the implications of disability and chronic illnesses with special attention to issues unique to Mormonism. Suggestions for professional intervention are provided.

Throughout Judeo-Christian history, examples of miraculous events abound. These experiences have been explained as manifestations of the power of God and as proof of God's working through His people. Enoch moved mountains and changed the course of rivers (Moses 7:13). In the desert, Moses caused water to spring forth from a rock that provided Israel's millions with water (Exodus 17:6).

In New Testament times, Peter healed a man who had been lame since birth (Acts 3:2–6). James taught that the elders should offer a prayer of faith to heal the sick (James 5:14–15). Christ taught that “signs” would attend his followers, including protection against poisonous serpents, and healings (Mark 16:18).

The restoration of the gospel through Joseph Smith was ushered in with many miraculous occurrences and heavenly manifestations. Latter-day Saints are taught that the priesthood is the means by

which Christ's followers bring about miracles. Each priesthood holder is taught that he has the power to act in the name of God. Priesthood blessings and healings are an integral part of Mormon theology and culture. Stories abound of personal lives touched by these events. Church meetings and conferences frequently include stories of the benefits of priesthood blessings. When medical, health, or psychosocial problems arise, priesthood holders are summoned, often in conjunction with or in lieu of professional help.

Every Latter Day Saint has heard scores of stories of healings and restorations to health as a result of priesthood blessings. Many have had these experiences personally. In those instances in which health has not been restored and an individual has died, survivors have felt comfort in the belief that the Lord needed the person on the "other side," or, "it was their time."

In recent years, an increasing number of people are surviving illnesses or disabling events who previously would have died. With advances in health care, people are living but rather than experiencing restoration of health, they have long-term health problems or disabilities. Psychosocial adjustment to illness and disability is often difficult as people are forced to cope with changes in lifestyles, activities, and roles. People who are LDS are frequently faced with another issue that can be as difficult to cope with as the condition. Many have been promised full restoration through divine intervention, but are left with long-term disabilities. This paper addresses the psychosocial implications for individuals and families who experience chronic illnesses or disabilities. Societal attitudes are discussed, as are issues specifically pertaining to LDS clients. The implications of unfulfilled priesthood blessings are addressed. Suggestions for working with LDS and non-LDS clients are provided.

Societal Reactions to Disability

In western society, people with disabilities are often relegated to invisibility or second-class citizenship. Physical access to public places and services have traditionally been limited (Richards, 1982). Access to education, employment, and social opportunities are

inadequate. The resultant lack of opportunities for people with disabilities to fully participate in society engenders ignorance and contributes to isolation (Ray and West, 1984).

Persons with disabilities are judged according to their limitations, not their strengths (Weinberg, 1983). A person with a mobility impairment is perceived as “confined to a wheelchair” or “crippled,” rather than as utilizing a wheelchair for mobility. People with short stature are called midgets or dwarfs. Rather than viewing the disability within the context of the whole person, the disability becomes the standard used to perceive the person.

Public exposure to routine lives of people surviving illness or trauma with lifelong health limitations or disabilities is minimal and usually inadequate. The recent portrayal of the life of an individual with paraplegia on a local television news magazine illustrates the type of exposure most people experience. The “tragedy” of his accident and the “hopelessness” of his resultant paraplegia was explained. Then the documentary dramatized his “heroic” efforts and “undaunted” motivation to train for and excel at wheelchair athletics. The story ended with comments from choked-up commentators about how inspirational this man was to other “crippled” people and to “us all.” No mention was made of the routine aspects of this man’s life or of his family and work. Another story chronicled an Olympic runner paralyzed in an automobile accident. He was shown as he was carried “helplessly” in his wheelchair down a flight of stairs. Viewers were left feeling the man had suffered a fate worse than death. These types of stories, combined with lack of exposure to the disabled as ordinary people, reinforce inaccurate and stereotypical views of life with a disability, in which people are seen as objects of pity or as inspirational figures overcoming overwhelming odds to achieve success.

Mormon culture at times unwittingly reinforces the inaccurate perceptions perpetuated by society. A review of the *Ensign* Magazine from January 1987 to July 1989 produced some interesting results. The terms “confined to a wheelchair” or “wheelchair bound” were used at least eight times. Other references to people with disabilities included such terminology as “victim of cerebral palsy,” “cripple,” and “risen above her handicap.” At

least nine articles referred to the chronically ill or disabled as objects of service. There were at least eight references to miraculous healings sparing the person death or disability as a result of faith and/or priesthood blessings. While these stories may be inspirational, unless they are balanced with stories that normalize life with illness or disability, they unwittingly reinforce negative stereotypes.

The Trauma of Unfulfilled Blessings

It is the responsibility of each priesthood holder to always live worthily to exercise his priesthood when the need arises. When acute illnesses, accidents, or other traumatic events, or acute psychological distress occur, blessings are frequently requested on short notice. The priesthood holder has little or no time to prepare before giving a blessing. The person and loved ones for whom the blessing is requested are in crisis and may have high expectations of the blessing. This places performance pressure on an already stressful situation. The motivation to pronounce a “satisfactory” blessing may be extremely strong. When the person giving the blessing is a loved one of the recipient, even more pressure is added. For example, when a father gives a blessing to his child who is gravely ill, he will desperately want to give a healing blessing. His wife and other loved ones may have strong desires for him to bless the child with health. In these situations, emotion can prevail over inspiration.

The following case example is illustrative. (Please note that all case examples are presented to assure anonymity.)

M.J., a 16 year old girl, sustained multiple injuries, including a severe head injury in a single car rollover. Her family was informed that her prognosis for survival was approximately 50% and that if she lived, she would be permanently and severely disabled. Her grandfather, considered a family “spiritual giant,” was called on to give the comatose M.J. a blessing. After a “powerful” blessing for healing, M.J.’s family felt confident that her grandfather’s promises would reverse the effects of the accident and that M.J. would return to health.

M.J. survived, and though she was blessed that she would be “made whole,” she has lifelong physical and cognitive deficits that will preclude her from returning to a normal life or allow her to live independently. M.J.’s grandfather carries much guilt in the belief that he failed his

granddaughter and disappointed his family. He blames himself for her condition, assuming that his faith was insufficient for M.J. to be healed. His feelings of inadequacy are intensified when he attends church meetings or listens to general conference addresses and hears stories of others who received blessings that restored them to full health.

The tragedy of M.J.'s injuries and subsequent disabilities is compounded by the confusion and guilt of her loved ones that the blessing she received failed to produce the intended results. M. J. is incapable of understanding her situation, but her family has been doubly traumatized.

The following example is illustrative of reactions individuals can have when blessings they receive are not literally fulfilled.

T.S., a 52 year old businessman, suffered a dislocation fracture of his eighth thoracic vertebrae, transecting his spinal cord and resulting in T 8-9 paraplegia when the motorcycle he was driving was struck by a car. Alert and oriented when he reached the hospital, yet unable to move or feel his lower extremities, he immediately requested that a long time friend and prominent church leader be called to give him a blessing. Within hours of his accident, T.S. was promised through this blessing that he would be "made whole" and that he would "walk out of the hospital." Throughout his initial hospitalization, though he experienced no return of neurological function, he remained confident that his health would be restored. For two months he participated fully in his hospital program "to do (his) part;" however, he refused to allow a wheelchair purchase because of the assurance he received that he would walk out of the hospital "whole."

Only when it became obvious three days prior to his discharge that he would not leave the hospital "whole" did he authorize a wheelchair rental. It took several months after that before he would begin to verbalize that his condition might be permanent.

Three years after his accident, T.S. was still befuddled about "what went wrong" with his blessing. He vehemently rejected suggestions that his blessing either was intended to reflect a future cure or was a promise intended for the resurrection. He was adamant in his conviction that he was promised that he would be healed before release from the hospital.

T.S. sought counseling from an LDS therapist after hearing in general conference of a young man who had a miraculous recovery from similar injuries. He was distressed at the speaker's explanation that the young man was restored to health because of the blessing he had received combined with his faith and hard work. As T.S. pondered the

implications of this story for him, he experienced an increasing sense of despair. He had experienced absolutely no return of function even though he had demonstrated all the faith as he was capable of and he had worked as hard as he could. Feelings of self-worth were negligible. He openly questioned God's love for him. He was also extremely distressed because other members of the church questioned his faithfulness when he was left permanently disabled after receiving a blessing from a respected church leader. He expressed suicidal ideations, stating the primary reason for not terminating his life was his fear of the "eternal consequences" if he did.

The stories of M.J. and T.S. graphically illustrate some of the intense problems faced by Latter-day Saints who are personally affected by long-term disabilities or chronic health problems. For some, the disappointment and confusion of unfulfilled blessings may be more difficult to cope with than the process of adjusting to their disability.

Competence in Counseling Persons with Disabilities

Therapists' comfort with disability have great implications for their therapeutic effectiveness. It is critical to see the clients' capabilities, not just the disabilities and deficits (Ben-Sira, 1986). Knowledge of the implications of a person's disabilities is essential. For example, knowing that paraplegia causes paralysis of the legs is insufficient. Depending on the level and severity of injury to the spinal cord, chest and trunk muscles can be affected, anesthesia below the injury is produced, and bowel, bladder, and sexual dysfunctioning can result. Likewise, when counseling an individual who has had a brain injury, it behooves counselors to understand the range of possible cognitive, emotional, behavioral, and social deficits they might encounter and with which individuals and families must contend. Counselors who understand the implications of their clients disabilities are much more likely to establish rapport and trust and develop effective treatment strategies than those who are not armed with this knowledge.

When working with LDS clients, counselors should be prepared for the spiritual concerns that frequently arise. Among these are doubts about self-worth and uncertainty about God's love or

power. The following sections outline some of these questions and provide suggestions for therapeutic interventions.

Spiritual Concerns

Most members of the church who become disabled are able to resolve their religious and spiritual concerns independent of professional help with the support of their families, and sometimes with the help of local church leaders. Those who seek professional help with their spiritual quandaries may be deeply troubled by them and will typically seek an LDS counselor who they perceive can understand and accept them. Frequently encountered questions include:

1. *“What have I done wrong that makes me unworthy to receive God’s blessings?”*

These people blame themselves for their problems. They believe they would be healed if they were worthy of God’s blessings. They become demoralized by their perceived unworthiness and inability to gain divine approval.

2. *“Does God love or care less about me than those people who have had miraculous events in their lives?”*

The power of God is not questioned, but the person’s relative personal worth is scrutinized, often with the conclusion that for some reason, God loves or cares less about them than others who have been beneficiaries of His divine intervention.

3. *“How could the church be true when I was promised that I would be healed and nothing happened?”*

These people are in danger of losing their testimonies of the gospel. They have been deeply hurt and disappointed and may begin to attribute any manifestation of priesthood power as coincidence.

4. *“How are my faith and actions inadequate for the Lord to help me?”*

This question is often asked when a blessing has been predicated on the faith and efforts of the recipient, who as a result, blames himself or herself on the lack of fulfillment. They believe that

somehow they did not work hard enough for the blessing's fulfillment. This self-denigration produces guilt and despair.

5. *"What was the matter with the person who gave me the blessing?"*

These people may blame their condition on the person who gave the blessing, reasoning that someone more worthy would have produced successful results. It is not uncommon for them to seek out others for repeated blessings in futile attempts to achieve the desired results.

6. *"Is there a God?"*

These people question whether a loving God could consign them to the existence they have. They are mourning their losses and see little hope for the present and the future. They have a tendency to become cynical and bitter.

These questions can shake spiritual foundations and clients may agonize over them for months or even years before seeking professional help. Likewise, loved ones of persons with disabilities may be unable to reconcile the disparity between reality and shattered expectations. The inclination to offer conventional explanations to these dilemmas should be avoided, as they will usually be rejected. These include:

1. *"The individual will be 'made whole again' in the resurrection."*

This gospel principle is a great comfort for members of the church. Everyone has this promise. However, this explanation does not address the lack of health restoration in this life. As T.S. stated when offered this explanation, "I was blessed I would be healed in the present. There was no reference to the resurrection." The promises of the restoration in the resurrection are unrelated to the immediate situation.

2. *"The disability is a test from the Lord."*

This explanation is difficult to accept when the person acquires serious cognitive deficits or develops uncontrollable dysfunctional behaviors, or, in cases of coma, lack of consciousness secondary to illness or accident. Similarly, it seems out of character for the Lord

to impose problems of this nature as a test. While people may use experiences as a result of disability for growth, and the Lord allows misfortunes to befall people, it is out of the Lord's character to create catastrophes for this purpose.

3. *"Hard work will bring the Lord's healing blessings."*

This explanation given to a paraplegic with atrophied and anesthetic limbs or to an individual with multiple sclerosis who has witnessed long-term deterioration of function with no realistic hope of symptom reversal will be viewed as wholly inadequate.

4. *"The individual is being used as an instrument in the Lord's plans."*

This statement may be valid for everyone from an eternal perspective. However, a God who brings tragedy to people for some unknown purpose seems incongruous with the God of Mormonism.

Though these frequently offered explanations are culturally acceptable, they are speculative and therapists are prudent to avoid using them to find meaning for the person's disability. Therapists may encourage clients to search for personal meaning from these speculations but should avoid offering them as explanations. It is important to acknowledge the fact that the reasons they were not healed may never be known. Therapists should also encourage clients to seek explanations directly from the Lord and to seek reassurance of God's love and concern irrespective of the disability. Eventually people need to concentrate their efforts on coping with the reality of the situation. They then can focus on the task of making happy, productive lives for themselves. Suggestions for counseling are outlined below.

Gospel Issues

Clients who come for counseling as a result of unfulfilled expectations for divine intervention may have more difficulty with this than with their disabilities. They may question the gospel principles they have been taught for years; in some cases a lifetime. Efforts to find *the* reasons for their current conditions have been futile, though most have experienced much speculation about their

situations. Some seek therapy, seeking explanations for their conditions—an expectation therapists cannot fulfill because the answers to these questions for individuals are rarely discovered. Rather than focusing exclusively on their blessings, clients should be encouraged to attend to their personal relationships with Christ and seek a reaffirmation of His love for them. In addition, attention to the larger perspective is often helpful.

A discussion of blessings in the church is desirable. It is important to help the client understand that the miraculous events they read about in scripture and other publications and those they hear about in church meetings are not *samples* of everyday events, but are *shining examples* of what can happen. Were they common events, they would not be the subject of the attention they receive. These accounts are not the norm; rather, they are exceptional situations.

It may be valuable to discuss with clients their perception of miracles. Many people ascribe divine intervention as the cause of events that have causes that are more complicated. In a recent fast and testimony meeting, a mother related the story of her daughter's brush with death. She told of her daughter's central nervous system infection that produced serious neurological symptoms and required emergency hospitalization. She talked of the blessing the child received shortly after admission to the intensive care unit, and her recovery that began shortly thereafter. A physician who was aware of the situation and heard this inspiring story mused on the miracle of modern science and the newly developed antibiotics that helped restore this girl's health. The majority of the congregation left the meeting that day with the belief that the blessing the girl received was *the* reason for her restoration to health. On the other hand, while appreciative of the priesthood, the physician left feeling more appreciative of the "miracle" of recent technology and antibiotics used to treat this girl and to the many others he had seen "healed" in a similar fashion.

It is important in therapy to address the circumstances of the accident or illness. A discussion of the stress and emotional effects on all involved may help the client put into perspective the pressure priesthood holders may feel when they receive emergent requests to

give blessings in times of crisis. This can help clients begin reframing the blessings from a personal or divine failure to a manifestation of desperation and love that led to inappropriate promises. This prepares clients to understand that individuals may let their feelings and desires override inspiration especially when there is inadequate time for spiritual preparation.

Intervention Strategies

A major focus of therapy for people with recent disabilities should be on living in the present and planning the future. Clients may tend to focus on their losses, mourn the past, and ruminate on things they could once do but are now unable to engage in. They need assistance to see the options still available to them. For example, a young amputee who loved basketball became distressed over his inability to play ward basketball with his friends. At the urging of his counselor, he began playing (and enjoying) wheelchair basketball. His teammates with similar disabilities exposed him to numerous other recreational opportunities and social contacts. In another situation, a woman with a serious visual impairment from diabetic retinopathy was able, with supplemental vocational training, to transfer her skills as a medical-surgical nurse to a mental health setting.

As clients begin to explore their potentials and recognize their strengths and abilities, they will develop the capacity to find pleasure in the present and plan for the future. For example, a parent who is mobility-impaired may be unable to engage in activities such as family hiking excursions, but may choose adaptive physical activities or other, nonphysically limited pursuits. In one family Mr. R., a 35 year old father of three young children, was unable to continue working as a mechanic after becoming paraplegic from an auto accident. Though he received Social Security Disability benefits, he became depressed over the loss of family income and insurance benefits. His relationship with his wife deteriorated as they struggled to deal with the physical implications of his disability and the lifestyle changes brought on by his situation, such as the dramatically increased amount of time they spent together. His wife had been a school teacher prior to their

having children but had worked very little for eight years. During therapy, the R.'s explored the possibility of Mrs. R. returning to her profession as a way of bolstering their finances and reinitiating medical benefits. This avenue was pursued successfully. Mrs. R. enjoyed returning to elementary school teaching. Mr. R. fulfilled the role of homemaker in the family. With Mrs. R. out of the home, Mr. R. felt less like a burden and more like a contributing member of the family. Although unable to engage in previous vocational pursuits, Mr. R. took pride in his responsibilities as a homemaker and primary care parent for their children. The R.'s were also able to spend time away from each other, thus alleviating some of the day-to-day stress they had previously experienced. As a result, their marriage and family relationships were strengthened.

Clients may need help in accurately assessing their present and future capabilities and in planning life goals and activities accordingly. In some cases, the use of physical, medical, and/or psychological evaluations may be valuable planning guides. This is particularly important in the presence of cognitive problems. For example, R.S., an engineer, sought counseling six months following traumatic head injury received in an automobile accident. Though hospitalized only three weeks, R.S. had been forced to leave her job because she was unable to do the work she had previously had done due to memory and reasoning difficulties. When psychometric tests revealed mild to moderate cognitive deficits, a program of cognitive therapy was instituted as an adjunct to individual therapy. In addition, vocational rehabilitation services were arranged to help R.S. find alternative work in a timely fashion. In this case, psychotherapy alone would have been insufficient. The necessary environmental interventions were made possible only after a thorough assessment of R.S.'s condition was completed. The therapist consulted with the rehabilitation counselor as she helped the client adjust to her head injury and develop strategies to compensate for her cognitive deficits.

Occasionally, direct intervention with significant others on behalf of clients is warranted. The vast majority of employers, ecclesiastical leaders, and friends will have extremely limited experience with persons with disabilities and will benefit from

minimal education and guidance. An employer may need information on physical accessibility to prepare for an employee's return to work. A bishop may benefit from suggestions on how to effectively use the services of a ward member with a disability as a resource. The counselor may be of value, then, as an educator, mediator, and, at times, as an advocate for the client.

Attention to sexuality is vital, especially when sexual and genital function are altered by the disability. Early sexual counseling and education for the physical implications prevents potentially serious problems that arise without prompt intervention (Mackelprang and McDonald, 1987). Guilt and fear prevent people from seeking help for sexual problems; thus, therapists may need to initiate discussion of sexual issues. Tasks in helping clients sexually adjust include exploring and increasing comfort with body image, assessing physical and sexual capabilities and limitations, and developing a repertoire of sexual options. To complete these tasks it is imperative that clients are sexually educated and are able to communicate their desires, wishes, concerns, and fears.

Summary

With continuing advances in medical technology, the number of people with disabilities will continue to grow. Latter-day Saints who acquire disabling conditions experience the same adjustment processes as others, but are often faced with the additional task of reconciling their spiritual beliefs with their physical limitations, especially when comparing themselves to the recipients of miraculous interventions. Increasingly, LDS counselors and psychotherapists will have opportunities to provide professional services, but in order to do so, must be prepared to assist with their clients spiritual and biopsychosocial needs. Therapists act as resources for clients as they attempt to adjust to altered lives and bodies. They can provide support as clients struggle to reconcile their feelings about the gospel. They are also valuable mediating and educational resources. With increased sensitivity and awareness of the problems people with disabilities encounter, we can assist them in the quest of leading full and productive lives.

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