THE FUNCTION OF RELIGION IN REHABILITATION OF CLIENTS WITH SPINAL CORD INJURY: AN AVENUE TOWARD PSYCHOLOGICAL ADJUSTMENT AND EMOTIONAL HEALING

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Contents

I would especially like to thank Dr. Lee,
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who saw me through yet another extraordinary endeavor.

Amen. It is finished! Amen.

Preface

"Pity never becomes more than a feeling.
Compassion compels us to act."

--Joni Eareckson-Tada

Eareckson-Tada, Joni. Choices . . . Changes. (Grand Rapids, Michigan: Zondervan Books, 1986: 141).

My interest in the topic of how psychological adjustment and emotional healing occurs after one experiences a spinal cord injury has been with me since I was very young. As a child of only ten years, I watched the movie Joni and both parts of the movie The Other Side of the Mountain with wide eyes and with a compassionate heart. Ever since viewing these films, I have been drawn to literature and to audio visual documentaries pertaining to the lives of people with disabilities, especially to those with spinal cord injuries.

During an interview for a position at Courage Center, a rehabilitation center in Golden Valley, Minnesota, the interviewer asked me where my interest in spinal cord injury originated. When I told the interviewer that I had watched these movies when I was younger, he was quite concerned that my ideas about people with spinal cord injuries were romanticized. He was concerned that I would not be able to deal with the deeper issues surrounding adjustment to physical disability. Although I wish that my passion for this topic could be explained in more personal terms than by simply watching romanticized movies about a former diver and a former skier, the truth is undeniable. I was an impressionable child whose eyes were forever opened to the needs of persons with physical disabilities, and this paper is one dimension stemming from my awakening. Another dimension associated with this awakening and with the writing of this senior thesis is my role as an intern at Courage Center. I am working with the art therapist on staff, and am independently pursuing interview opportunities with individuals whose insights are relevant to my topic.

Throughout this thesis, it will be my goal to successfully describe how religion can act as a force to stabilize the psyche, and to promote an understanding of how religion inspires emotional healing. An underlying theme which will be obvious throughout this paper is the importance of having chaplains, or representatives of religious study, available to clients in rehabilitation centers. I believe this resource is absolutely vital in helping clients cope with questions, doubts and concerns related to human suffering.

After the spinal cord has been damaged, it is necessary to rehabilitate not only the physical body, but also the psychological mind. Psychological well-being not only determines the general well-being of a client with spinal cord injury, but it may also determine whether one's life continues at all. In this thesis, I describe the client's process of adjustment, struggling to desire to live again. First, I will share my understanding of the specifics of spinal cord injury. In order to understand how a person must become psychologically adjusted to a spinal cord injury also requires an understanding of the physical ramifications of the injury. Chapter one, therefore, is an effort to familiarize readers with some specifics pertaining to spinal cord injury. Next I describe why religion has been largely ignored in reference to rehabilitation. Finally, I suggest that religion has the potential to stabilize the emotional states of a client with spinal cord injury by offering him or her a stable, focussed and accessible "personal center."

This topic of how religion acts as a resource to stabilize the psyche is very close to my most inner self. It makes theological discussion regarding religion and emotion available and applicable to a frequently overlooked and ignored population. Too often, I feel, academic pursuits are simply efforts to entertain one's self and one's fellow academicians.

Perhaps if society knew of those things which are discussed at a very scholarly level, our aspirations of attaining an ideal world would be closer to reality. My senior thesis is an attempt to bridge the division between the scholarly realm and the societal realm in an effort to move us perhaps a touch closer to this ideal goal.

Introduction

"Can anything be given to use more directly than our own personal experience?"

--Viktor Frankl

Frankl, Viktor E. The Doctor and the Soul. (New York: Knopf, 1972: 33).

One day when I was ten years old I was introduced to the healing power of religion and to the healing power of Christianity in particular. It was a Sunday morning, and, as usual, my family and I attended our 8:00 a.m. church service. We filed into our familiar pew, and opened our bulletins to read the announcements and treasurer's report just as we did every Sunday. This particular week, however, there was a special insert in our bulletins. The insert introduced us to Joni Eareckson, a young woman who was sharing the Christian gospel in a film about her life. The same afternoon, my mom took my older brother and me to the movie Joni, showing at the Paramount Theater in Brainerd, Minnesota. The film moved me in a way that I have been unable to forget. It filled me with compassion, yet I have not acted upon this sense of compassion until this semester. It is exciting to finally address my own questions and concerns pertaining to the rehabilitation of persons with physical disabilities. Furthermore, it is exciting to have the opportunity to focus my study of persons with spinal cord injury on religion and to articulate these thoughts in a paper of this depth.

To begin, I feel that it is necessary to introduce my readers to the individual that was instrumental in my own awakening, to the individual who opened my eyes to the needs of those with physical disabilities. More importantly, she will be referred to throughout the paper as a specific reference and example of the issues that I will be raising regarding rehabilitation and emotional adjustment. This individual is Joni Eareckson-Tada.

At the age of seventeen, Joni Eareckson was a vigorously active and independent young woman. She loved athletics, especially swimming and diving. In the summer of 1967, however, Joni dove into the Chesapeake Bay for the last time. The water engulfed Joni as she crashed to the bottom of the shallow Bay, breaking her neck and permanently losing the use of her arms and legs. Joni writes of the accident and her resulting paralysis in her autobiography entitled Joni. She describes her ordeal with suicidal thoughts, depression and eventual victory over helplessness and total dependence. Joni attributes her success over these challenges to Jesus Christ, her constant source of strength.

Joni describes the onset of paralysis as being

> . . . a jumble of actions and feelings. . . .I felt my head strike something hard and unyielding. At the same time, clumsily and crazily, my body sprawled out of control. . . . I was lying face down on the bottom [of the Bay]. . . . Why are my arms tied to my chest? . . . I tried to kick . . . Panic seized me. With all my willpower and strength, I tried to break free. Nothing happened. . . . (Eareckson 1-2)

Finally, Joni's sister Kathy pulled Joni from the water. Joni tried to clear her mind and to dissolve the confusion, but surrealist illusions confronted her. She felt that her arm was tied to her chest, but she saw that it was slung lifelessly over Kathy's shoulder. When the raft was pushed onto shore, Joni tried to get up but felt pinned to its plastic. "Kathy bent over and held me close. I couldn't feel her hug" (Eareckson 4).

Joni believed that the numbness would wear off at any moment. Not until Joni was in the hospital and alone in her cubicle did she realize how serious her condition truly was.

> [The nurse] put a sheet over me and left. . . . The sheet slipped down, exposing part of my breasts, and I couldn't move to pull it back up. Frustration and fear finally brought a flood of hot tears as I began to sense the seriousness of the situation. (Eareckson 6)

Joni describes in shocking candor the horrors of being both a victim a the patient. She documents her surgeries and her rehabilitation sequence in great detail. Finally, Joni shares her spiritual struggle, beginning with her rebellion against any type of faith and closing with her eventual trust in God. Joni began to trust in God as a personal center, enabling Joni to accept that her injury was permanent, and that, despite her paralysis, she would live a satisfying life.

In her epilogue, Joni writes,

> Wouldn't it be exciting if right now, in front of you, I could be miraculously healed, get up out of my chair and on my feet?. . . . But far more exciting and wonderful in the long run would be the miracle of your salvation--the healing of your own soul . . . that's more exciting because that's something that will last forever. If my body were suddenly and miraculously healed, I'd be on my feet another thirty or forty years; then my body dies. But a soul lives for eternity. . . . (Eareckson 175)

One aspect that sets Joni's biography apart from some other stories of people with disabilities is that the message, intent and goal of her writing is religious. Joni tries to communicate with other individuals, disabled and able-bodied, that human suffering is not a punishment for an individual's sin or wrongdoing. Rather, Joni describes her suffering as a pathway to wisdom, teaching her that to trust in God is the only way to true acceptance of the vulnerability within the human condition. This wisdom replaces the necessity of asking "Why, God?" Joni believes that God guides and directs her. She believes that all of humanity may embrace the same God to guide and to direct them as well.

Today Joni shares these revelations in an organization she has developed called "Joni and Friends." This Christian ministry is specifically directed toward people with disabilities. The response to "Joni and Friends" has been amazing. Thousands of individuals with disabilities have found that they, too, can peacefully accept their condition by turning to God. Despite their physical limitations, they have discovered a sense of worthiness in themselves through hearing the healing power of the Christian message.

This spiritual avenue toward strength and endurance such as Joni's is the topic of this paper. What inspired the rebellious and depressed teenager to adjust to using a wheelchair for mobility and adaptive devices for grooming, feeding and writing? What enabled Joni to accept the "forever-ness" and the "permanence" of her limitations? What empowered Joni to confidently address thousands of people, sharing her life and her struggles? What caused such an extraordinary change in her character?

Within the rehabilitation center itself, there were no professionals on staff for Joni to approach with her pertinent religious questions. Her gradual spiritual and emotional healing occurred after her lengthy hospitalization and rehabilitation. While a representative of religious study might have been able to help Joni with her struggles before she left the hospital, today most rehabilitation centers still do not accept the need for chaplains. For many like Joni, spiritual and emotional healing occurs because of a faith in God--a belief that, even in suffering, there is a reason for living, a reason to overcome all of the trials that lie ahead. Rehabilitation administrators need to begin accepting the fact that religion is a valid resource for stabilizing emotional destruction caused the bitterness and hopelessness caused by paralysis. Once administrations understand the importance of religion in the healing process, persons with spinal cord injury may begin addressing their concerns to a trained professional.

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Chapter One:

Coping With Spinal Cord Injury

"Science without religion can be destructive;
religion without science can become superstition."

--J.B. Feibelman

Feibelman, J.B. "Men of God and Science." Journal Mississippi Medical Association. [(4): 389-393, September 1963].

Among the most traumatic of physical disabilities are those which occur at an age when one can realize the consequences, and which impose immediate, complete and permanent effects. Spinal cord injury is one such disability which affects a person's ability to carry out many activities of daily living. The physical challenges always affect ambulation, and sometimes require altered techniques in grooming and feeding. These changes in daily activity are too often described in terms of physicality alone. The altered performance of the body also has a dramatic impact on the psyche, and emotional adjustment is certainly as difficult if not more difficult than physical adjustment. At the single moment when the spinal cord is severed or damaged, changes occur which will confront the person for the remainder of his or her lifetime. Family relationships often become stressed, daily routines may become frustrating and previous forms of leisure or vocational activities may take a great deal of energy, and, therefore, may no longer be possible or satisfying. The individual must struggle to adjust to a new definition of self, both physically and mentally.

My desire is to educate and to implore our society to accept those with physical disabilities as full, contributing members of society. Despite the fact that the injured individual remains valuable, important, loving and lovable, people who have had no previous exposure to or experience with people with physical disabilities will almost certainly devalue the worth of these individuals. In a country where we like to believe that cultural diversity is respected, diversity within each ethnicity should also be recognized. One element within every ethnicity is the potential for physical disability. Acceptance of differences is one way in which each of us can positively contribute to people's adjustment to their injuries and resultant disabilities. We may, in fact, be helping our own futures. As members of the "temporarily able-bodied" community, it is important to understand the similarities as well as the differences that have alienated us from those with physical disabilities. Perhaps with understanding will come tolerance, and with tolerance, acceptance.

Spinal cord injuries result in varying losses of movement and feeling. An injury to the spinal cord may produce temporary or permanent dysfunction which is either incomplete or complete. Incomplete lesions result in motor and sensory function which is partially intact below the level of the injury, whereas complete lesions result in motor and sensory function which is totally lost below the level of the injury. Thus, motor and sensory function will vary depending upon the level of the injury, and implications for future functioning may vary significantly for two individuals who are injured at the same vertebral level if one has a complete lesion and the other has an incomplete lesion (Trieschmann 4). Those injuries occurring at the neck, or cervical level (corresponding to the "C" level) of the vertebral column will result in quadriplegia, if complete, or quadriparesis, if incomplete. Quadriplegia results in the inability to move or to feel all four limbs of one's body, while quadriparesis results in the inability to move or to feel only portions of all four limbs. Those injuries occurring at the trunk or low back, or thoracic, lumbar or sacral regions of the vertebral column (corresponding to the "T", "L" or "S" levels) will result in paraplegia, if complete, or paraparesis, if incomplete. Paraplegia results in the inability to move or to feel both lower limbs of one's body, while paraparesis results in the inability to move or to feel portions of both lower limbs (see figure 1, Trieschmann 5).

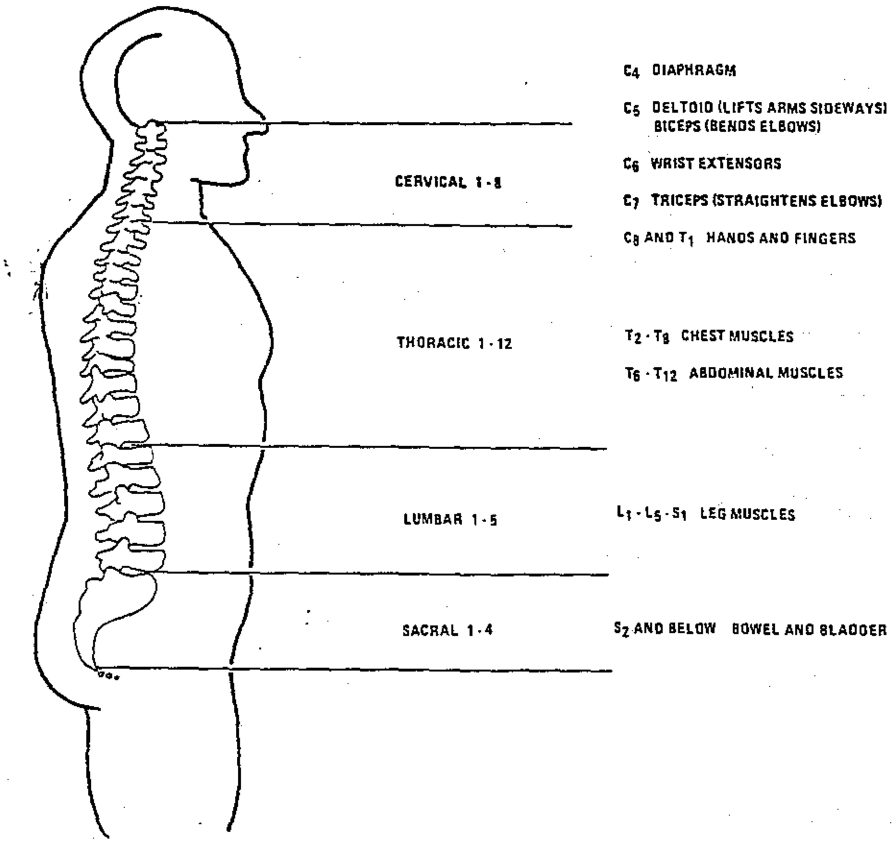

Figure 1. Vertebral Column and Nerve Supply.

The ability to care for oneself, defined in spinal cord literature as levels of independence, are variable with the onset of quadriplegia since quadriplegia involves injury to the vertebral column from the levels of C_1 through C_8. Those injured at the levels of C_1 and C_2 will have no motor function below the head. They will be unable to breathe without the use of a respirator. Independent function will be limited to the use of the muscles of the face. Consequently, these individuals will require almost total assistance. Injuries at the level of C_3 lead to paralysis below the neck, but some shoulder function may remain intact. Breathing will still require the use of a respirator, and assistance will be required for many activities. Electric wheelchairs equipped with a portable respirator provide increased independence. They may be controlled by head or shoulder movements. Joni Eareckson was injured at the level of C_4. The upper extremities remain paralyzed with injury at the level of C_4, and some assistance is still required, although these persons do not require a respirator. Persons with injury at the level of C_5 will be able to use their shoulders and biceps, permitting some upper arm mobility, but an electric wheelchair remains the essential mode of transportation. The potential for true independence begins at the level of C_6. At this level, people retain the ability to extend their wrists, allowing them to transfer into and out of the wheelchair without assistance. An electric wheelchair is not necessary, and some people are able to drive an automobile with hand controls. However, finger function is absent. At the level of C_7, independence is probable, although finger dexterity is still markedly impaired. At the level of C_8, independence is almost assured, depending upon the individual, for finger function is preserved at this level (Trieschmann 5-6).

Although independence is virtually always possible in the cases of paraplegia, much emotional and physical adjustment is still necessary after being injured between the levels of T_1 through S_4. Injuries between the levels of T_1 and T_8 involve paralysis of the chest and trunk muscles, abdominal muscles and leg muscles. All functions are performed through shoulder, arm and hand movement alone. Balance and trunk stability are a potential problem, so a manual wheelchair is frequently used. Injuries at T_9 and below allow for ambulation with long leg braces and crutches since these injuries impair leg and hip function. Extensive locomotion by this method, although possible, expends a great amount of energy and consequently many individuals prefer to use wheelchairs (Trieschmann 6).

While many injured individuals are greatly concerned with their future independence and satisfaction, there are many immediate and serious medical concerns which accompany spinal cord injury. To prevent further damage to the spinal column, every effort must be made beginning at the scene of the accident to immobilize the spine. Once the patient reaches the hospital, surgery is often performed to stabilize the vertebral column. Persons with cervical injuries may need traction to maintain absolute stillness upon the neck. This involves immobilizing the head, customarily accomplished by drilling holes into the skull and inserting tongs which attach to a metal frame. Respiratory function is maintained by a respirator for those with high cervical injuries. Catheters are inserted into patients' bladders to insure adequate urine drainage. Intravenous fluids are administered to maintain a proper balance of fluids and electrolytes. Every two hours, the patient is turned on a specially designed bed called a stryker frame to prevent pressure sores from developing. When movement is possible without the risk of further injury to the spinal cord, physical health is restored.

Medical concerns accompany the individual with a spinal cord injury throughout life. There may be a loss of the sense of touch, temperature, pain and position. Since pain is a warning signal that something is wrong, the loss of the pain sensation can be extremely serious, even fatal. Sensory impairment is significant since injury may occur to anesthetized parts of the body without the person's awareness. Burns may occur from water that is too hot, close proximity to heaters and extended exposure to sunshine. Frostbite in northern climates is a possibility unless skin temperature remains monitored. To adjust and to shift position is normal in able-bodied persons; in this way, pressure is constantly relieved and redistributed. People with spinal cord injury do not sense discomfort which would urge them to shift position. Therefore, pressure sores develop where the skin breaks down from constant pressure. Another medical element requiring monitoring is bladder and bowel function. Bladder infections frequently occur, and the loss of calcium from the bones increases the chance of kidney and bladder stones. In fact, kidney damage is one of the primary causes of death in those who survive the initial spinal injury (Trieschmann 8). Blood pressure must also be monitored. Autonomic dysreflexia is a reflex in which a person's blood pressure suddenly elevates to dangerously high levels. Unless blood pressure is rapidly reduced, a cerebral hemorrhage may occur. Distention of the bladder is the most common cause of this problem.

Joni tells of a time when she struggled with this illness.

> "Jay! Judy!" My voice is urgent. I have been awakened in the middle of the night by a pounding headache. My heart is racing It is not with fear. Something is desperately wrong with my body.
>
> "Jay!" I wait for an answer or for someone to flick on a light in the adjoining room.
>
> Jay stumbles into the room. "What is it?" She reads the panic in my eyes. "Oh, Joni. You're sweating buckets!"

"I think it's my catheter. It must be blocked or kinked or something." I breathe deeply, trying to control my heart rate. "Do something, please, quick."

Jay goes into high gear and throws back my covers. She turns me on my side and discovers that I've been leaking around the catheter. "The bed is soaked. Your bladder must be bursting!"

I think of the two quarts of water I drank before bed, a necessary part of my nighttime routine. I haven't gotten rid of any of that fluid. I'm in dysreflexia--a dangerous reaction in spinal cord injured people that can result in cerebral hemorrhage.

"I'm going to change it. We don't have time to fool around." Jay scrambles urgently through the dresser for a new catheter, syringe, sterile solution and scissors.

My head is hammering. I know my blood pressure is shooting up rapidly, uncontrollably. I try not to think about a brain hemorrhage.

Within minutes, a new catheter is inserted. "Come on . . . drain bladder, drain," Jay whispers nervously as she looks for a flush of fluid in the clear urological tubing.

I cannot tolerate the pain. "What's happening? Why isn't it working?" I cry.

"I don't know. I don't know! "I've checked everything. It must be a faulty catheter."

I read panic in my sister's face. She knows as well as I how dangerous this is. Doctors have warned us. We've read about it in books. But this is the first time it had happened. . . . "Oh, God, forgive me. Forgive me for knowing what to do one minute, then forgetting the next. . . ." (Eareckson-Tada 1986, 55-56)

After the paramedics came, a new catheter was inserted and the bladder was able to drain before a cerebral hemorrhage occurred.

Temperature regulation is also important after a spinal cord injury. Comfort is made difficult by an inability to shiver, to conserve heat, and to vaporize heat in warm climates. Finally, limited chest expansion during breathing and an inability to cough adequately to remove secretions in the lungs make a person quite vulnerable to respiratory infections, influenza and "colds" (Trieschmann 10-11).

After the spinal cord has been stabilized, rehabilitation formally begins. Traditionally, rehabilitation has focused on teaching mobility and activities of daily living (ADL). Mobility training is primarily the responsibility of the physical therapist, and includes the learning of skills such as changing position in bed, transferring into and out of the wheelchair, and if the injury was sustained in the lumbar or sacral region, ambulating with braces and crutches. Activities of daily living are primarily the responsibility of the occupational therapist, and include the relearning of activities such as bathing, grooming, bladder and bowel management and homemaking skills. Occupational therapists also have extensive knowledge in the creation and use of adaptive devices which will assist the person in accomplishing certain tasks.

Recognition of the fact that physical and occupational therapists were unable to adequately rehabilitate the entire person led to the concept of comprehensive rehabilitation. Efforts were and continue to be made to transform the rehabilitation center from a custodial institution to a "therapeutic community" (Palmer 1968, 22) which treats all aspects of the person, both physically and mentally. In this attempt, a team approach to rehabilitation was initiated. In addition to physical and occupational therapists, the new rehabilitation services provided support of the client by such people as physicians, nurses, psychologists, family counselors, social workers, vocational counselors, recreational therapists, orthotists (experts in brace manufacture), transitional specialists and, sometimes, chaplains. The quality, efficiency and efficacy of the rehabilitation process is ultimately correlated with the quality, efficiency and efficacy of the communication between and direct practice of individual team members.

Among the most serious of neglected areas in traditional rehabilitation was in the area of psychological support and adjustment. Recent scholarship in the field of spinal cord injury has concentrated on defining the psychological stages of adjustment. Authors tend to describe the initial stage of reaction as one of psychological shock in which pain, fear about survival, sensory and perceptual deprivation, sleep disruption and drugs account for much of a person's behavior. When survival has been relatively assured, the stages of denial, depression and mourning occur, not necessarily in that order. It has also been noted that not every patient goes through every stage, and some authors suggest that depression and mourning are negatively correlated with adjustment. Others argue, suggesting that although depression and mourning may slow the rehabilitation process, these stages are necessary in dealing with the extreme life changes that will confront the person for the remainder of his or her life.

Familial relationships are another dimension which influence a person's adjustment to life after spinal cord injury. The literature seems to agree that if the family communicates an attitude of worth to the disabled person, he or she is more likely to fully participate in the rehabilitation process, which ultimately encourages preservation of one's self-concept. Studies on marriage relationships suggest that marriages are less likely to succeed after a disability occurs. Spouses in post-injury marriages seem happier and more satisfied than spouses in pre-injury marriages. In pre-injury marriages, men and women with disabilities have described more feelings of guilt for "being a burden" than in post-injury marriages. One way of coping with a severe disability is to learn to minimize problems and hassles, and to concentrate on the positive aspects of life. This, however, may lead to misunderstandings between a married couple. The disabled partner may be viewed as minimizing the difficulties involved in everyday life of which the able-bodied partner is all too well aware. If children are involved, the disabled parent may worry about asking too much of his or her child since the adult may need the child's assistance with many daily activities. If the children are very young, the quadriplegic must deal with personal emotions while watching someone else care for their child. Furthermore, spontaneity in social situations is difficult because much of family activity revolves around the personal attendant's schedule, and because even just going out to a restaurant involves much more planning than it would for an able-bodied couple. Open lines of communication become increasingly important for the survival of a marriage when disability is involved (Trieschmann 94-97).

The parental reaction to an adolescent's injury is another dynamic within the family which influences a person's psychological adjustment. Applying the family systems theory, the family that has experienced the spinal cord injury of a member will attempt to fit the new situation into existing patterns. When old patterns are not successful, the family goes through a period of disequilibrium before successful change. However, if the family system and its resources have been too taxed, growth may not occur (Murray 228). Some general questions are raised in using the family systems theory. Parents whose marriages are enhanced with good communication skills, who do not have additional current stressor events, who have access to and who are willing to use adequate formal and informal support systems, and, finally, parents who possess adequate coping and resource management skills will be better able to cope and to encourage their son or daughter through the rehabilitation and life process after sustaining a spinal cord injury (Murray 228-233).

While familial relations are undeniably relevant to psychological adjustment after spinal cord injury, it is apparent that these elements in conjunction with the full team approach to rehabilitation neglect one issue that is equally relevant to psychological adjustment: the issue of religion. Religion seems to retain its taboo in the field of medical and psychological science, for even today rehabilitation centers are battling to hire on-staff, inter-faith chaplains. Even in some rehabilitation centers with a chaplain, corporate, ecumenical worship is not allowed. Unfortunately, the patient is the victim in the battle between faith and science. In 1965, Dr. Frederick Whitehouse addressed the American Psychological Association Symposium on Psychological and Religious Dimensions in the Diseased Disabled by saying,

> Many of us, in our presumptuousness, either consciously or unconsciously destroy a patient's religious faith. We reveal our attitudes by the avoidance of an issue, by our condescending

> tolerance, and by the impatience in our voices. By consciously, in a well-meaning but questionable effort, or by unconsciously weakening a patient's faith, we may deprive [the patient] of an important resource, undermine the foundation upon which [the patient] stands in times of crises, or rob [the patient] of beliefs which provide enough comfort to sustain [the patient's] balance. (Palmer 1968, 16)

These dilemmas which Whitehouse described in 1965 are still of concern today, in 1992.

After studying the necessity of a team approach which includes a representative of religion, it would appear that all of the bases are covered, so to speak. The discussion thus far has been positive, investigating adjustment during rehabilitation as if adjustment occurred in one-hundred percent of those who incur a spinal cord injury. In fact, few authors discuss rehabilitation that is not successful. Courageous stories such as The Other Side of the Mountain, discussing the former skier Jill Kinmont, emphasize the inspiring lives of those who have proven that the tragedy of spinal cord injury does not mean that life has to end. These stories prove the opposite: that life goes on, and that life can continue to be satisfying, even successful. Yet one must question the optimism behind these reports, for there is an abundance of material discussing psychological adjustment to spinal cord injury. The underlying assumption in the existence of this literature is that all who become disabled are not successfully rehabilitated. Even with the team approach, some people do not adjust to their situation. What happens when emotional healing does not occur?

One reaction common for persons with spinal cord injury which would suggest non-adjustment is that of panic disorder. Panic disorder is most frequently described as the interpretation of normal anxiety sensations misperceived by the client as being more dangerous than they really are. The person becomes increasingly sensitive to those sensations which inspire anxiety, and the person learns to associate those sensations with the onset of an anxiety attack. The attack then occurs, reinforcing the person's belief that the original anxiety sensations were life threatening. This reinforcement produces a vicious circle in which the person becomes increasingly susceptible to attacks. For example, a nineteen-year-old paraplegic male was readmitted to the hospital three years after receiving a spinal cord injury at the level of T_1 because he complained of episodes of intense fear with an overwhelming sense of impending doom or even death. The attacks would last from ten minutes to several hours, and had increased in frequency over the three months previous to admission. Although he initially denied fears of specific situations or places, he noted that the attacks were made worse when he left his apartment or when he entered a new place where he felt isolated (Marshall 346-347). This patient's inability to successfully adjust to his disability is illustrated in his inability to accurately interpret his anxiety as related to foreign environments. Instead, he interpreted this anxiety as life-threatening, which propelled him into a state of panic. Medication was prescribed to alter the patient's reaction, and advancements in adjustment are expected to coincide with the taking of the drugs. Yet administering drugs to alter this reaction may not adequately address the underlying issue, that adjustment to the spinal cord injury has not occurred.

While some people will seek treatment for panic disorder, others might determine that their disabled existence is no longer worth the effort of living. These individuals may either take their own lives, or they may ask another to end their life for them. Joni Eareckson-Tada discusses euthanasia in her most recent book, entitled When Is It Right to Die? She comments that hundreds of people with severe disabilities are killing themselves through lethal injections or pills administered by a family member or a doctor (Eareckson-Tada 1992). Thousands, Joni writes, are being told that this is a compassionate way to deal with a disability. At one point in her own rehabilitation sequence, Joni recalls asking her friend, Jackie, to help her commit suicide.

> "Jackie--I can't take it any more. I'm dying, Jackie. Look at me. I'm almost dead now. Why do they let me suffer like this?"
>
> "I--I don't know, Joni."
>
> "Jackie, you've got to help me. They're keeping me alive. It's not right. I'm dying anyway. Why can't they just let me die? Jackie--please--you've got to help," I pleaded.
>
> "But how, Joni?"
>
> "I don't know. Give me something--you know--an overdose of pills?"
>
> "You mean you want me to kill you?" Jackie asked, wide-eyed.
>
> "Yes--I mean no--you won't be killing me. You'll just be helping me die sooner. Look, I'm already dying. I'm suffering. Can't you help me end the suffering? If I could move, I'd do it myself!" I was angry and frustrated. "Please--cut my wrists--there's no feeling. I'd have no pain. I'll die peaceful, Jackie. Please! Do something." (Eareckson, 37-38)

Jackie refused to give in to Joni's desire to have her life ended. Joni implores others to do for their disabled friend or relative as Jackie did for her.

The final stage in formal rehabilitation is the transition into the community. When the team of specialists determine that the client is functioning at one's highest mobility and ADL potential, discharge to the home or another independent living environment is recommended. Once discharged from the rehabilitation center, variables such as family dynamics and employment opportunities influence the person's attitude regarding one's self and one's disability.

The occurrence of spinal cord injury initiates a sequence of rehabilitative stages to help the individual adjust to his or her situation. The ultimate goal of rehabilitation is to introduce the individual to a life which is not only healthy, but also satisfying. The traditional methods of rehabilitation, those which concentrated only on mobility and on activities of daily living, ignored pertinent and absolutely necessary elements of the psyche. Traditional rehabilitation ignored emotional healing. Recent developments in rehabilitation have instituted the team approach, where a team of experts work together in one environment to help the client adjust to all aspects and effects of the spinal cord injury. Many theories discussing familial relations and the team approach to rehabilitation expand our concepts of the intricacies involved in adjustment to physical disabilities. Although these studies are interesting and informative, scientists and specialists have tended to ignore, in my opinion, the equally important aspect of religion. A few authors and doctors have recognized the relevance of religion as an important resource which patients of spinal cord injury may turn to for strength and encouragement. Few, however, are willing to contribute much time to the actual study of religion in rehabilitation. How does religion act as a factor of motivation to help the person accept the disabled situation and a new concept of self? How does religion affect the disabled person's attitude? How does religion inspire hope for the future? These and other issues will be discussed in the next chapters on religious issues involved in rehabilitation and on spirituality and emotional healing.

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Chapter Two:

The Role of the Church and Religious Issues Involved in Rehabilitation

"Even though our physical being is gradually decaying,
yet our spiritual being is renewed day after day."

--II Corinthians 4:16

Throughout Western history, the church had the sole responsibility of caring for the spiritual concerns of its disabled members because the secular world refused to believe that religion deserved a place in its professional centers. The medical, scientific world neglected religion, terming it unempirical, unscientific, and offensive. More recently, however, the clergy and persons providing pastoral care have been fighting against the seemingly more popular notion that religion is irrelevant in the rehabilitation process. At the same time, pastors working in individual parishes still carry much of the counseling load because people with physical disabilities continue to search for answers to existential questions and to questions concerning human suffering. The are still unable to get the answers they need within the context of rehabilitation services. The desirable institution encourages individuals to embrace a faith in which they might find strength. It is necessary, I believe, to continue developing resources for people with disabilities, for when society recognizes the positive value and worth of its citizens with disabilities, a true step toward acceptance of diversity will have been made.

The history of the treatment of persons with physical disabilities in America reveals a traumatic past. One author traces the progression of such treatment in eight societal stages. The earliest stage is referred to as the extermination stage and describes the period when persons with disabilities were considered to be malformed, and were killed because society believed these people to be displeasing to the gods. Later, they were abandoned or were tolerated as a source of entertainment and amusement. The third stage is referred to as the custodial stage, where persons with disabilities were recognized as needy and were given alms.

Finally, in stage four, efforts were made to meet medical needs. It was recognized that people with disabilities were capable of learning independent living skills, thus inspiring the fifth stage, that of education, where schools were established to meet the educational needs of this population. After the first World War, society felt responsible for disabilities resulting from the War, and the sixth stage attempted to vocationally rehabilitate soldiers who had become disabled. Finally, in about 1940, the concept of total rehabilitation developed to include social and psychological consideration which climaxed in the present stage, the concept of comprehensive rehabilitation. In this final stage, many different specialists work with the client to help the client develop skills, but all of the therapies are integrated to keep rehabilitation consistent and directed (Palmer 1968, 35-36).

The custodial stage in rehabilitation marked a turning point in attitude toward persons with physical disabilities. Finally these persons were not only allowed to live, but they were given provisions of food and shelter to help them survive. These charities were organized by Christian churches. Thus, the first positive actions directed toward persons with physical disabilities were delivered by the church.

A person with a disability needs strength as much outside of the church's walls as within its doors, but without sufficient guidance and without adequate responses to theological questions, the individual with a disability may not find strength inside or outside of the church. The need to understand how religion acts as a resource to stabilize the psyche is of primary importance, for when this is understood, it may be taught to students in clinical pastoral education, leading to its actual practice by chaplains in rehabilitation centers. However, if we continue at the present rate we will never attain this goal. Almost every author involved in the discussion of religion and rehabilitation limits their arguments to the responsibilities of the institutional church for meeting physical needs of members with physical disabilities. While this focus has raised many congregations' consciences to the needs of their disabled members, the argument ignores the needs of individuals with a disabilities outside of the church. If a person finds strength inside of the church, the same strength should be internalized so that it might become a resource outside of the church as well. Without the ability to walk, move or physically feel a part or even a majority of one's own body, simple answers regarding the coming Paradise and God's forgiveness are insufficient responses to questions regarding their suffering, and the questions deserve deeper insights and more lengthy discussions than often are possible given a pastor's work load. The simplest solution to this dilemma is to have a chaplain available in all rehabilitation centers to help clients work through religious issues, concerns and questions.

Christians are not the only people subject to spinal cord injury and to physical disability, of course, and so it is necessary when considering the role of religion in rehabilitation to include in the conversation more voices than just those of the Christian church. Other faiths, those of the non-Christian population, ought to be heard as well. I recognize the need for further discussion regarding other religions' treatments of their disabled population, but I find this paper too brief to give justice to this pursuit. Therefore, I leave this discussion to future researchers.

Although the responsibilities of the church to persons with physical disabilities are given some attention in specific religious and specialized journals, the role of religion in general is largely ignored in books and articles written to describe psychological adjustment to physical disability. It is, indeed, amazing how few authors describe, or even mention, the role of religion at all. Even in resources dealing with various aspects of life after sustaining a spinal cord injury, authors fail to mention religion, faith or God (Palmer 1968, 4-5). This fact is even more astounding when one considers the universality of the question "Why me?" Frequently, answers to questions of personal suffering and tragedy are found in reference to a power not of the earthly realm. This is where, I believe, a chaplain or another professional in religion and science should be invited to enter the conversation in scholarly writings, yet few of these professionals are heard.

One factor which may have contributed to the deficiency of scholarly research in the area of rehabilitation may be researchers' fears of being accused of holding unscientific attitudes.

> Since religious sentiment does not lend itself readily to analysis, the psychologist who investigates it is accused, by some, of . . . missing the richness of the gestalt, and, by others, of . . . losing . . . scientific respectability. (Palmer 1968, 7)

Although these same professionals recognize the inadequacies of present research instruments and methods, the problem remains that empirical studies involving objective measurements, control groups and statistical analysis are simultaneously inadequate for researching issues pertaining to matters of faith and belief (Palmer 1968, 7). Another possibility for the deficiency of research in the area of religion and rehabilitation is the potentiality for offending separate denominations (Palmer 1968, 7). Even this, however, is not an acceptable excuse to deny the vital resource of religion from rehabilitation centers. Finally, and sadly, another reason for the lack of research in this area may be the fault of the educational system, which permits professionals to be licensed without even a single course in ethical theory or philosophical thought. The root of this problem is the inability of administrations to recognize the value of human life and human dignity. Clients are individuals with real feelings and with real problems, and are the ultimate receivers of these professional skills. Ethically speaking, therefore, the process of education ought to remember those that will be receiving the medical skills in the end, those who may need psychological assistance in answering their philosophical, religious questions. Even a recent study of practitioners in the clinical setting indicates that attitudes toward religion in the secular, professional setting continue to neglect religious concerns.

> . . . perhaps a strong bias against using religious-related . . . concepts in therapy exists in the professional community, which inhibits professionals from practicing in ways congruent with their more general belief systems. (DiBlasio 171)

As a result, professionals are too often unaware of and unprepared to deal with questions of moral and ethical concern (Palmer 1968, 9).

Professionals in theology and religious studies are combating the efforts of others to silence their voices.

> Recognizing that the traditional language of theology seems incredible to many who are saturated with scientifically derived concepts, and believing that any revelation of truth is a partial revelation of God, some theologians are turning to the sciences for help in developing a coherent and credible doctrine. They are convinced that religion requires a credible system of belief if it is to motivate commitment. In an age when secular behavior increasingly is based on scientifically warranted belief systems, a religion

> which denies its own need of a credible belief system or theology is likely to suffocate itself. (Palmer 1968, 11)

Instead of remaining silent, theologians are attempting to incorporate scientific language into their arguments. Perhaps by speaking the language used by health care professionals, the legitimacy and necessity of a place for religion in rehabilitation centers will be recognized as a vital resource for emotional healing.

Throughout history, churches were the only resources disabled individuals had for religious questions concerning their condition. The church had the sole responsibility of providing "inspiration, fellowship, a sense of direction, awareness of the reality of God, redemption, salvation and deliverance" (Palmer 1961, 15). These elements of inspiration, fellowship and salvation have the potential to encourage and to motivate the person with a disability to develop remaining skills. Ironically, it is also possible that the church may fail to contribute the hope an individual with a disability needs to face one's future with a positive attitude.

It may be argued that some congregations fail to encourage adjustment, although defining which specific denominations fail to encourage adjustment has proven problematical. In an effort to study denominational differences, Charles Palmer in his book Religion and Rehabilitation collected data on different denominations' treatments of their members with physical disabilities. His study reveals a deep complexity making it impossible to assert that one specific denomination is detrimental while another is constructive. Palmer asserts that "churches are frequently thought of as falling somewhere along a continuum from the most liberal to the most conservative. There are, however, many other continua to be considered" (Palmer 44). Among these continua are elements such as the spirituality or material nature of a person and the moral "maturity" or fundamental nature of the individual. These aspects suggest that it is incorrect to even argue that the more liberal or the more conservative denominations will or will not encourage psychological adjustment to a physical disability. Rather, a combination of aspects lying somewhere between and in differing combinations between liberal and conservative denominations will best encourage adjustment. Palmer offers a chart of religious differences (see figure 2, Palmer 1968, 44). In addition, Palmer explains

> It is readily concluded that some of these positions, attitudes, or emphases will contribute positively to mental health; others will have the opposite effect. It is also obvious that as religious groups differ in their major emphases, they differ in the manner and extent to which they prepare persons for life in a complex world--a life which, for some, involves dealing with a [physical disability]. (Palmer 44)

Major Emphasis	**Major Emphasis**
<u>Liberal</u>	<u>Conservative</u>
A way of life	A system of concepts
Symbolic Interpretation	Literal acceptance
Spiritual	Material
Harmony with science	Supernatural causes
Morals and ethics	Orthodoxy (fundamentalism)
Intangible satisfactions	Tangible awards
Assertion of the worth of the individual	Negation . . . worth . . . individual
Hope and trust	Fear and anxiety
Redemption	Sin and guilt
Growth and change	Original sin
Ecumenical	Exclusive
Cooperation	Prejudice and bigotry

Figure 2. Religious Differences.

This chart presents a readily accessible categorization with which to compare different denominations. Furthermore, this chart suggests that a combination of religious aspects contributes to healthy adjustment. While some aspects may lie on the liberal end of what should be looked upon as a continuum, others may lie on the conservative end. Palmer does not specify which of these aspects are necessary for or even correlated with positive adjustment. He presents the religious aspects to emphasize the complexity within such an analysis, stating ". . . the student of religions will want to add others--complicating still further the difficulty of understanding all differences" (Palmer 1968, 44).

Although churches may appear to "encourage" their "exceptional" persons, different denominations have different policies and programs for instructing their disabled populations. Different churches also have different methods of counseling these individuals. Some churches have written official statements describing exactly how they will attempt to counsel their disabled members. In some congregations, members must accept these positions; in others, members are free to accept or to deny them. Other denominations have not issued official pronouncements regarding rehabilitation or treatment of their disabled members. Furthermore, there is an element of hypocrisy involved in this procedure of policy-making. Even if the church hierarchy professes one treatment pattern, different individuals within the hierarchy may differ in talent and patience when actually confronting issues of religion with a disabled, and perhaps, rebellious member (Palmer 1962, 363).

Some churches attempt to motivate their disabled population by suggesting that the disability is a punishment for sin. These denominations are more destructive than effective. Likewise, some denominations have more "thou-shalt-nots" and believe that sickness and disability are evidence of the wrath of God. Some churches go even further by suggesting that if the person repents of their sins and asks God for forgiveness, the disability will disappear. Members of these congregations insist on coping with their pain without medical advice and, therefore, do not cooperate or participate in traditional notions of a healing program. The idea that disability is a punishment for sin may retard recovery or make the individual confront insurmountable obstacles. When a disability is viewed as the wrath and punishment of God, the vital will to live may be impaired or destroyed (Palmer 1968, 76).

Motivation and locus of control influence a person's adjustment to physical disability. Internal motivation, as well as external rewards and punishments act as driving factors toward complete rehabilitation. It has been suggested that it may be possible to differentiate between well motivated and poorly motivated individuals along four continuum: existence of realism and clarity of goal-striving ambitions, acceptance of suitable value-standards and behavior patterns, demonstration of adequate tolerance for frustration-producing experiences and, finally, an increasing degree of autonomy as suggested by the development of more egalitarian feelings toward other human beings (Rabinowitz 799). A person's notion of whether or not they have personal control over reward greatly influences motivation. Those with more of an externalized locus of control, or those who believe they have little control over reward and punishment, believe that rewards and punishments occur as the result of luck, chance or fate. Those, on the other hand, with more of an internalized locus of control believe that rewards and punishments occur as the result of their own actions. It has been noted that persons with spinal cord injury with an internalized locus of control spent less time in the hospital as the result of nonhygienic behavior, were more satisfied with life, and spent more time in educational activities, in leisure activities outside of their homes and, finally, in paid employment and community work.

Pastors or chaplains working with persons with physical disabilities have the opportunity to discover whether the client has an internalized or an externalized locus of control, and by so determining, may develop the internalized locus of control for constructive adjustment, while indicating to the client that the externalized locus of control is destructive. This theory of motivation is especially relevant to the chaplain-client relationship. Persons with an externalized locus of control may believe that they have little control over rewards and punishments. For some persons, this might suggest that God has willed the spinal cord injury as punishment for sin. And, as discussed earlier, this association with spinal cord injury as occurring because of punishment for sin is negatively correlated with adjustment.

Religious approaches to rehabilitation, therefore, take on a life and death importance which may bypass the importance of all other rehabilitative therapies. Adoption of an encouraging religious technique necessitates general adoption of broader religious practices which tend to compliment the therapies undertaken in a rehabilitation center. Physical and occupational therapy will not overcome feelings of futility and worthlessness if the individual has decided that life has no value without the ability to walk or to groom oneself. The person with a physical disability has a great need to recognize spiritual realities and religious ideals to instill fulfillment, poise and contentment in life (Palmer 1961, 26). These realities may offer the individual a new and relatively stable focus if offered by a church aware of appropriate and inappropriate responses to questions regarding disabilities.

On the other hand, some churches do encourage psychological adjustment by offering the religion as a stabilizing center, and this center is either graciously accepted by persons with disabilities, vehemently denied or adamantly ignored. Disabled members of a single, Christian denomination were asked why they philosophically believed that the injury happened to them. There were five responses that were most frequently answered. First, members believed that "God did this as punishment" (Palmer 1968, 47). As described above, such a response pertaining to punishment is negatively correlated with healthy adjustment and may indicate that adjustment has not and might not occur. A second common response was "Because God loves me, He has given me this cross to bear for Him, and I must bear it gladly" (Palmer 1968, 48). This response indicates a more positive acceptance of disabilities and limitations, one which could influence all aspects of rehabilitation. Others replied, "Now I must rely on God" (Palmer 1968, 48). This response indicates a stronger faith, and is closely related to the fourth response, " . . . although at this time I do not see how, I believe that all things work together for good to those who love God. Somehow this is a blessing in disguise" (Palmer 1968, 48). This response indicates a trust that God is actively aware and cares about the injured individual. A final response is somewhat related to process theology, and may indicate a higher understanding, a strong faith, and a positive attitude toward adjustment. "God had nothing to do with it. [God] does not will suffering or imperfection. God has established laws. Medicine and science are discovering more of them all the time. When we fully understand [God's] laws we will be able to minimize, decrease, or even eliminate suffering. . . . " (Palmer 1968, 48). If nothing else, this attitude indicates a hope for the future, and the element of hope can mean the difference between a happy, contented life or a miserable existence resulting in suicidal death.

While this single, Christian denomination seems to have contributed to positive adjustment in its disabled members, there are frequently differences between those who adamantly profess their faith in God and those who are true-believers, people whose faith actually influences or determines behavior. Sometimes, even patients who ask for a Bible to be next to them are uncooperative, fail to follow instructions and complain about minor details (Palmer 1962, 364). It has been suggested that these individuals are insecure, whereas a "desirable" religious faith would make a person more secure. These alterations in character would make an individual more co-operative, more appreciative of the hospital staff and less critical of minor irritations (Palmer 1962, 364). Therefore, when questioning a person with a disability about their faith, it is important to pay attention to actions as well as words.

From the standpoint of rehabilitation, it is more important to know what the person with a disability believes or does not believe than to know what the person says is his or her belief. The individual's actual belief is reflected in his or her attitude toward the situation, and in the decisions the person makes, even if these beliefs are not verbally expressed (Palmer 1968, 6). In recent years, it has been accepted among professionals in psychology and psychiatry that religion serves as an important variable in solving personal problems. Therefore, it seems obvious to me that religious beliefs should constitute a factor not to be ignored in the process of rehabilitation. The chaplain can recognize whether a person's religious beliefs and practices are constructive and positive, or whether they are interfering with the rehabilitative procedures. The professional could then attempt to utilize constructive beliefs while encouraging the client to replace beliefs that are correlated negatively with rehabilitation (Palmer 1968, 6-7).

The point of all of these studies is that a religious faith, or a belief in a power beyond oneself that affects the operation of what is within oneself, motivates or has the potential to motivate a person with a disability to accept the disability, to strive to obtain one's remaining potential, and finally, to interact with society. One author describes this source of motivation as spiritual well-being. "Spiritual well-being is the affirmation of life in a relationship with God, self, community and environment that nurtures and celebrates wholeness" (Ellis 58). These definitions strive to emphasize a love of life that contributes to healthy attitudes and resultant behaviors.

If a person lacks a strong belief that there is control and meaning behind all life, including meaning behind human suffering, the devastating effects of spinal cord injury can be insurmountable. Suicide is often the way out for depressed individuals while others turn to chemical substances as an escape. A recent study indicates that strong religious beliefs which include a faith in God have a relationship to the adaptive cognitive beliefs that people adhere to as reasons for not committing suicide. Jon B. Ellis and Peggy C. Smith conducted a test of spiritual well-being, social desirability and reasons for living. The results of these scales indicated that there is a dramatically high correlation between religious well-being and moral objections to suicide (Ellis 61-62). For those individuals who are religiously oriented prior to an accident, therapists may more easily intervene with the use of religion, whereas for those individuals who are very secular-minded prior to an accident, the use of religion in therapy is probably not effective as a means to prevent suicidal thoughts.

The church is oftentimes referred to as a source of strength and comfort. While the church may influence a faith, it is the faith embraced by individuals which serves as a source of strength and comfort (Palmer 1968, 55-56). Before one embraces a faith which results in positive adjustment, there are a number of factors which influence a person's likelihood of well-being. Concepts and attitudes held before a spinal cord injury will influence the resultant behavior. If a person delighted primarily in one's body, the client will probably find the loss of function even more devastating than one who delighted primarily in the mind. Similarly, if one was not religiously inclined before the injury, it is not likely that one will become immediately involved in religion after the injury. Religious questions will, however, probably be addressed soon after the onset of injury, and the way the disabled person responds to a religious questions indicates a great deal about attitude and expectations.

While the church has been given the primary responsibility of counseling religious aspects of the individual, other, even secular institutions have begun to recognize the importance of religion in the rehabilitation of the whole person. Comprehensive rehabilitation centers, for example, have adopted the philosophy that spirituality contributes to health, recovery and wholeness. Consequently, the more progressive centers across the United States now have a chaplain on staff, at least part-time, to help clients work through religious questions and concerns. Likewise, seminaries have begun offering clinical pastoral education to train students in how to deal with the religious questions and concerns of individuals with a variety of disabilities, among them, those with spinal cord injuries. A final positive aspect resulting from the church's original concern for the needs of persons with physical disabilities is that of community acceptance. Although societal prejudice has not been entirely eliminated, society is beginning to accept its population of persons who are disabled. For individuals with spinal cord injuries, this includes accessibility laws and legislation requiring equal opportunity in the job market. Finally, a glimmer of the ideal has begun to shine, revealing the potential for the future. Yet it has not progressed far enough, in my opinion, for there are still too many who leave the rehabilitation facility without having the opportunity to confront and to discuss their spirituality.

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Chapter Three:

Spirituality and Emotional Healing

"The human heart seeks the infinite because that is where the finite wants to rest."

--Paul Tillich

Tillich, Paul. The Dynamics of Faith. (New York: Harper and Row Publishers, Inc., 1957: 13).

Perhaps rehabilitation counselors panic when clients ask questions regarding human existence, reasons for suffering, and ultimately and integrally related to these, reasons for living. Often, the counselor's initial belief is that the person is depressed, and may be on the verge of suicide. Yet these questions are deeply rooted in human nature. One need not be physically disabled to wonder why an individual life is planted, grows and then withers. Neither does one need to be physically disabled to wonder why some of that time is spent crying, and why other times are spent laughing, or to wonder if the laughter adequately balances the times of sadness and loneliness. Almost everyone considers questions like these at some point before earth loses its hold on the individual, and life fades into eternal, earthly silence. Yet these questions are more threatening when posed by individuals with disabilities because their need for answers is more pronounced. Existence as the individual once knew it is gone, and a new existence has been forcibly initiated. Questions inevitably will be raised; the responses to which are sometimes shallow, sometimes profound.

The goal of rehabilitation is to help the client make satisfactory adjustment to one's disability. Adjustment must not be defined as accepting one's limitations and society's expectations of those limitations since this type of adjustment is destructive rather than supportive. Rather, adjustment is accepting one's limitations while simultaneously striving to reach and to share one's potential. Positive adjustment is demonstrated by an individual who looks for possibilities in the present and future rather than dwelling on possibilities that were realistic in the past (Easton 230-234).

Although the church was instrumental in raising consciences to the needs of persons with physical disabilities in the past, it is no longer sufficient as the only resource available to individuals with physical disabilities and with psychological questions. Too few will seek answers from a pastor, priest or congregation with a majority of able-bodied members. Instead, a chaplain must be available to work inter-faith in a place where these persons will seek conversation. The professional must be prepared to deal with questions concerning life and death from the perspectives of various religious faiths. The chaplain must be prepared to address the inner-most essence of clients as they are, not as they used to be. These answers lie within questions of existentialism, of the meanings of suffering, and of the reasons for living. To complicate the situation even further, the answers, the meanings, and the reasons will not be the same for every person who enters the conversation, for each person has one's own concept of emotional well-being and of personal spirituality.

Unfortunately, it appears that psychology has begun to emphasize the similarities between individuals which are more easily analyzed on an empirical, correlational level. This empirical approach makes it convenient to believe that one case is exemplary of all, and that the procedures that were able to aid one person's well-being will also work for the next client who enters the conversation. Differences between individuals, however, are equally relevant and informative. One counseling method that acknowledges the differences between clients is the "existential" method. The chaplain who is operating from an existential viewpoint realizes that the only similarity between clients is that they are clients. Thus, the existentially oriented chaplain searches for what makes an individual unique.

> The client is not concerned with the problems of others, but with [one's] own anxieties, uncertainties, and confusion; in a word, [the client] is concerned with [one's] own existence. To treat the client as just another client violates the client's integrity and worth, and, in effect, objectifies [the client] as opposed to humanizing [the client]. (Dreyfus 115)

The chaplain must be an open and honest listener. The chaplain should allow the client to work through issues that the client raises. In this light, the chaplain is not only listening. Instead, the chaplain is allowing the client's world to "unravel" in terms of an "existential encounter" (Dreyfus 115). Professionals who have used this method believe that both the chaplain and the client begin to learn about the client's world through the existential encounter. After such a session, the chaplain is better able to share with the client what the chaplain understands of the client's world. From a clear, mutual understanding, the client and the chaplain may continue to work through troublesome topics while moving on to address new issues. The ability for the chaplain to be human, therefore, and to be willing to learn as the client learns is of great influence. Neither will grow unless both are open to learning from the other.

One characteristic difference between a non-existential and an existential system of rehabilitation is that in existential rehabilitation, there is a great deal of freedom. In non-existential rehabilitation, many clients have similar routines and have similar expectations placed upon them. It may be easier for clients to function in non-existential settings, because the client escapes the anxiety and pain that are associated with making decisions. At the same time, however, the client has lost a great deal of personal identity which cannot be afforded at this point because so much has already been lost to the injury itself. Therefore, freedom in existential rehabilitation begins a process of healing for these injured individuals. The ability to make one's own decisions and to learn how to live independently can inspire hope and motivation for the future while simultaneously reassuring the individual of his or her own personal identity.

The client may not reach this potential, however, until the question of "why?" has been satisfactorily addressed and answered. Although a client may learn new methods of performing activities of daily living, the person may not find particular meaning in them, just as "[t]he activity of an anthill can be called purposeful, but not meaningful" (Frankl 1972, 27). Rehabilitation tends to be most successful when individuals have addressed and are contented with the belief systems that have meaning for them.

Meaningful and empowering belief systems may be found through discourse with others about a higher power. The intricacies involved in the discussion are many, as are the benefits. If one can find a faith in something outside of oneself yet integrally within oneself, meaning and value of life can be found, and in meaning, strength.

> It is self-evident that belief in a super-meaning--whether as a metaphysical concept or in the religious sense of Providence--is of the foremost psychotherapeutic and psychohygienic importance. As a genuine faith springing from inner strength, such a belief adds immeasurably to human vitality. To such a faith there is ultimately, nothing that is meaningless. (Frankl 1972, 33)

Some clients search for the meaning of life in pleasure, creating a disheartening problem for chaplains who are trying to help a client find meaning and strength in a faith. Pleasure ought not to be the "goal of our aspirations, but the consequence of attaining them" (Frankl 1972, 35). Pleasure certainly helps a person enjoy life, yet pleasure cannot make life meaningful unless the source of pleasure itself is meaningful. ". . . [J]oy is always directed toward an object" (Frankl 1972, 40), so the object must in itself be pleasurable. Such fulfillment through an object is, of course, infrequently possible.

The remedy to this obstacle is to find meaning not in what is outside of oneself, but to find meaning in what is within oneself. The person with a disability may find inner-strength and contentment in developing the concept of a higher power as a personal center. This avenue toward psychological adjustment and emotional healing grounds the person on a faith which is within, while still concentrating on what is ultimate, that is, that which is beyond inner constraints. Paul Tillich, a modern theologian, comments that a personal center ought to be one which concentrates on what is ultimately important, and, when properly directed, this ultimate concern will give a person unity, wholeness and centeredness.

> The ultimate center gives depth, direction and unity to all other concerns and, with them, to the whole personality. A personal life which has these qualities is integrated, and the power of a personality's integration is [one's] faith. (Tillich 105)

This Tillichian notion of a personal center has as its strength the eternal and personal characteristics of unconditional care mediated by a loving God. If a person, before the onset of the disabling condition, made one's personal center one's spouse, one's career or one's automobile, elements which are temporary and physically perishable, the disability may become even more devastating. The spouse or even the injured individual may find it impossible to continue the married relationship and, therefore, might choose to seek a divorce. With the divorce will come not only the end of the marriage, but if the spouse was the personal center of the individual with a disability, the divorce also signifies the loss of "centeredness," of control, and of contentment. The loss of that which was the personal center compounds the devastating effects of the initial injury.

Betsey Barton, in her book entitled And Now to Live Again, mentions a girl whose spine was injured in an automobile accident. Barton says this girl

> . . . was one of the rare people who began their adjustment beautifully. She went right to work and started to gain in strength and the ability to use braces. She wrote me she felt so strong during this period that she longed to have the whole world come and lay its troubles on her shoulders because she had enough courage to carry them all. She was filled with a love of life and things living--a holy compassion, which did not leave her and which made all her days joyful.
>
> She was engaged at the time to a young man who loved her and stuck by her through this. She felt happy in his love and secure. Yet when the war came, he was drafted, and he became uncertain of their future, so he broke the engagement before leaving for his induction. And he broke her heart. The long delayed reaction to her disability now crashed over her with all the fury of a long pending thunderstorm. She collapsed, gave up her attempts to get well, went to bed. She wrote that a broken heart was certainly much harder to recover from than a broken back. And I believed her. (Barton 26-27)

Joni had a similar realization.

> After my accident, I had clung to Dick, then Jay, Diana, and until now, Donald. I needed their love and support to satisfy my emotional needs. Now, however, I felt free. It was as if I had finally gained emotional independence on God. One day, while sitting outside in my wheelchair, I was quietly reflecting over these thoughts. Lord, I prayed, I wish I could have seen this earlier--I wish I'd have remembered that your grace is sufficient for me. . . . (Eareckson 155)

Likewise, the same painful reaction might occur if one loses the capabilities to hold the same career, or to drive the same automobile. Tillich believes these centers to be idolatrous, for they separate the individual from the infinite. "The more idolatrous a faith the less it is able to overcome the cleavage between subject and object" (Tillich 12). Personal centers directed to those elements which are truly infinite and unconditional are capable of giving a person a solid ground to face the events of one's future with strength and courage. "The human heart seeks the infinite because that is where the finite wants to rest" (Tillich 13).

A personal center concentrated on Christ, for example, unites the individual with the infinite. By concentrating on the infinite, one's confidence is not based on an external element. Rather, it comes from within, and all aspects of daily living, including the troublesome tasks of eating and grooming suddenly appear slight in comparison to eternal aspects of showing love, peace and understanding to others. ". . . there is a place where the ultimate is present within the finite world, namely, the depth of the human soul. This depth is the point of contact between the finite and the infinite" (Tillich 61). Finally, when these elements are combined, a person's confidence and outlook allows the person to share himself or herself more openly with others, giving not only love and mutual needs, but also sharing deeper insights and profound thoughts that are understood only in light of great suffering.

When a tragic event occurs, many people search for basic, essential, fundamental truths because they are better able to gain insights into life, and experiences are interpreted in a truer perspective. When a spiritual person experiences crisis, that person will most likely cling to the basic beliefs of his or her faith. Often, this spiritual person comes to a realization that humans are made up of three differing aspects, those of body, mind and spirit, and that the three must be considered together. If a person with a disability looks to the great power of the spirit, and refuses to allow the spirit to be damaged as the body was, there is evidence that the person "can rise above the severe [disability] and can become a stronger person in the process" (Morrissey 766).

> The center unites all elements of [one's] personal life, the bodily, the unconscious, the conscious, the spiritual. . . . In the act of faith every nerve of [one's] body, every striving of [one's] soul, every function of [one's] spirit participates. . . . Faith . . . is the centered movement of the whole personality toward something of ultimate meaning and significance. (Tillich 106)

At times, the person with a disability may feel alone, desperate and helpless. The emphasis on what is within does not remove the risk of further loss and destruction. Risk comes with every endeavor. Because of risk, however, success gives a more complete feeling of accomplishment, and the consequence of this success over struggle may be pleasurable. "...if the content of someone's ultimate concern is Jesus as the Christ, such faith is not a matter of a doubtless certainty, it is a matter of daring courage with the risk to fail" (Tillich 101). The person may overcome these negative and destructive notions by identifying and concentrating even harder on this power that is greater than oneself. Under the influence of this great, spiritual power, "paralyzing fear is replaced by trusting confidence, despair gives way to hope, and reality can be faced without dismay" (Morrissey 766).

In order to best serve a client, it is essential that the chaplain grant the client the freedom to make decisions. The client must contemplate, acknowledge and confront those issues which one finds troubling, and the chaplain must respond to those concerns with openness, accepting that the present client is unlike the client that was in the office previously, and is unlike the client that will be next in the office. If the client addresses questions in the direction of the "ultimate" or the "infinite," and the psychologist is ill-prepared to deal with the depth of these issues, then the client ought to be directed to a chaplain. Together, the chaplain and the client may concentrate on the meaning of life and explore the issues related to suffering which the client may find too great to overcome. With time, however, clients may begin to find strength in their own belief system. They may find strength to initiate or to rely on that which is beyond themselves, yet integrally within themselves. The client may look to the ultimate for a point of reference, to remind himself or herself that the past is to be remembered, that the present is fleeting and that the future is not insurmountable.

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Conclusion

"For the best is only bought at the cost of great pain."

--The Legend of the Thorn Bird

McCullough, Colleen. The Thorn Birds. (NY: Harper and Row, Publishers, 1977: i).

What began as a childhood interest in spinal cord injury and rehabilitation has become an intriguing senior project revealing not only the vulnerability of life, but also an avenue leading to hope, centeredness and community. Most everyone fears experiencing an injury which requires life-long adjustment. These fears and vulnerabilities are inescapable, they are integral aspects of human existence. Inevitably, some people will become injured and will be unwillingly thrown into a new world which must be internally processed and understood before a contented, productive life can be resumed or begun. At the same time, becoming physically challenged may encourage strength and a faith which is stronger and more mature than it was prior to the injury. I have intended throughout the writing of this paper to emphasize the productive minds of individuals with physical disabilities and to encourage society to openly approach persons with physical disabilities as contributing members of society.

The history of the treatment of people with disabilities is offensive. First, people were executed; later they were thrown into a circus tent or cage to be laughed at and to "amuse" an audience. Spinal cord injury, fortunately, in some respects, does not have this sort of dehumanizing history. Most persons who acquired a spinal cord injury died almost immediately after the injury occurred from medical complications resulting from trauma to the spinal cord. After medical practice became more effective in saving lives, however, another form of life needed to be saved, that of the psyche. Thousands have lost the desire to live, and have ended their suffering by ending their lives. Not only are these deaths painful for family members and friends, but the consequences of these deaths are painful for society as well. With the loss of these lives society has lost more voices, voices that could have explained human pain and trial in a new light, from a different perspective, and in a new combination of words. Those who have combated depression victoriously are able to explain how they triumphed and why they desired to live again. I believe we are all invited to learn from these voices.

After the spinal cord has been damaged, it is necessary to rehabilitate not only the physical body, but also the psychological mind. Psychological well-being not only influences the physical well-being of a client with spinal cord injury, but it may also determine whether life continues at all. In this thesis, I have described this struggle to desire to live again. First, I shared my understanding of the specifics of spinal cord injury. In order to understand how a person must psychologically become adjusted to a spinal cord injury requires an understanding of the physical ramifications of the injury. Chapter one, therefore, is an effort to familiarize my readers with some specifics related to spinal cord injury. Almost every article or book written on spinal cord injury requires at least a working knowledge of what occurs at each level of injury. In many of these sources, the levels are not explained. For example, a sentence merely states "He was injured at the level of C_4," and assumes that the reader will understand what exactly an injury at the level of C_4 entails for the future, as well as how it was immediately treated in the hospital. Next, I described why religion has been largely ignored in the rehabilitation process. Finally, I theorized that religion has the potential to stabilize the emotional states of clients with spinal cord injuries by offering clients a stable, focussed and accessible personal center.

The focus of rehabilitation regarding persons with spinal cord injury has varied throughout history. Rehabilitation began in an effort to assist the client to physically cope with the activities of daily living, then eventually expanded to a comprehensive rehabilitation, addressing psychological, emotional, vocational and recreational concerns. Even after participating in a program of comprehensive rehabilitation, a client may continue to need support from professionals, depending upon such variables as motivation, loci of control and familial relationships. Religious factors are also indicative of adjustment, either contributing to emotional adjustment, or, if the religion advocates understanding the injury as a guilt-producing form of punishment, contributing to further emotional destruction. Maladjustment can lead to a number of responses which may result in substance abuse, panic disorder, or even suicide.

After coping with psychological and physical issues in rehabilitation centers, the client must face the transition into the community. This may be an exciting time for the person with a spinal cord injury. Freedom from sanitary surroundings and generic decorations may be viewed as a blessing. But it may also be a very frightening time. All of the previously mentioned issues as well as family dynamics and employment opportunities continue to influence the disabled person's attitude toward living. The combination of these factors, if not positive, may destroy his or her vital will to live. It is also in this transition to the community that the person may confront societal prejudice in its most painful, alienating form.

Individuals who participated in traditional rehabilitation programs face another issue of freedom after re-entering the community. They may need to confront their belief system and determine what significance it has in their life, and how they must enrich or sustain that system. Occasionally, a related issue becomes apparent in this process. The person with a spinal cord injury might realize that he or she is angry at God, and this anger needs to be addressed to further positive, healthy adjustment.

The church, as an institution, has held the primary responsibility throughout history of caring for the spiritual needs of its members with physical disabilities and of helping people cope with existential emotions such as anger, fear and confusion. In the past, persons who did have doubts about God and God's "omnibenevolence," and who wanted to discuss theological issues, had to do so in the framework of the church. Different denominations treated their population of disabled persons in different ways, however, and while some were positive and contributed to healthy adjustment, others were destructive both to the individual and to the individual's concept of God.

Recognizing the need for earlier intervention in the rehabilitative process, it is becoming more accepted that inter-faith representatives of religion serve an important function in rehabilitation centers. To encourage wider support, professionals in religious study are developing a more scientific language to compete with empirical and correlational minded health-care professionals. Currently, a chaplain is on staff in some progressive rehabilitation centers to help clients cope with many issues, among them anger and the question, "Why me?" These professionals encourage positive adjustment by encouraging the client to trust in their own belief system. If the chaplain recognizes that a client's belief system seems to be destructive, the chaplain may communicate one's concern for the client and attempt to direct the client to a more constructive system.

When a client with a physical disability recognizes that his or her faith is instrumental in emotional healing, it is crucial for the chaplain to recognize that rehabilitation styles are significant factors which may encourage or destroy the chaplain-client relationship, and, similarly, may encourage or destroy the client's concept of God. An existential setting recognizing the differences between clients allows the chaplain to meet the client physically and psychologically, and to establish relations allowing them to address further issues. If the chaplain recognizes characteristics of a faith that seems to suggest that the spinal cord injury is the result of guilt and punishment, the chaplain may attempt to encourage the client to move to a different, more positive understanding. However, it is important to always respect the client's belief system. Likewise, if the chaplain recognizes that the client is dependent upon a conditional, temporary means of support, the chaplain and client can work together toward changing the client's personal center into something more stable, secure and readily accessible. Christ is one example of an effective personal center demonstrating characteristics of unconditional support, ultimacy and immanence. With Christ as the vision of the ultimate, all experiences that are frustrating and troubling may be interpreted in a broader perspective, and may, perhaps, become less frustrating and less troubling. "From the standpoint of eternity, my body is only a flicker in the time-span of forever" (Eareckson 175). So, too, are all our lives.

The most amazing aspect of this research project has been its implications for all of us. Humanity has so much to learn about unconditional acceptance, including the acceptance of persons with spinal cord injuries. Even after society begins to understand the concepts of acceptance and integration, the process of putting these concepts into practice is a long and difficult endeavor.

The endeavor may begin, however, when we recognize our own disabling condition, and our own inability to accept or integrate those who are labeled "different." If we could learn to do this, it would no longer place such extreme pressure on persons with physical disabilities. These individuals can easily feel contented and satisfied with their lives if they are not constantly reminded of their differences by staring eyes, inaccessible buildings and unequal opportunities in the job market. Improved treatment on the "outside" might encourage more strength on the "inside."

The life of one who has experienced a spinal cord injury is, at the outset of the injury, wrought with uncertainty and pain. The process of healing, however, illustrates the will to overcome adversity and to be victorious despite devastating circumstances. After reading numerous accounts about persons with spinal cord injury and after working with clients at Courage Center, my most prominent emotions are compassion, admiration and awe. One cannot help but wonder how oneself would react to such a life-changing situation. As easy as it might be for us to admire these inspiring individuals, those who have experienced spinal cord injury beg us not to admire their courage or to extol their strength. Rather, they believe that the majority of us would respond in similar ways, with comparable strength, and with the same stubborn will to live a full and contented life.

> If you have a son, or a husband, or a friend, who has suddenly joined the ranks of [persons with disabilities], you are privileged. Through them you can watch this process of rebirth take place. . . . Just as the study of the insane helps us to understand our own behavior more clearly, because we see ourselves and our behavior dramatized and distorted, so will the study of and participation in the reeducation of a person who has been suddenly hurt, help you to understand yourself. For here, in exaggerated and visible form, is bared the fretwork of human character in the making under pressure. . . . The heroic, stubborn will to survive raises its impressive head. And some who long for death will not die because of this instinct, which is stronger than ourselves, and that pulls us through sickness and shock long after our conscious striving has ceased. (Barton 5)

The words of these individuals with physical disabilities remind me of a legend which eloquently expresses my concerns.

> There is a legend about a bird which sings just once in its life, more sweetly than any other creature on the face of the earth. From the moment it leaves the nest it searches for a thorn tree, and does not rest until it has found one. Then, singing among the savage branches, it impales itself upon the longest, sharpest spine. And, dying, it rises above its own agony to out-carol the lark and the nightingale. One superlative song, existence the price. But the whole world stills to listen, and God in His heaven smiles. For the best is only bought at the cost of great pain...Or so says the legend. (McCullough i)

My belief is that God has looked upon the persons with spinal cord injuries as the thorn birds on the savage branches. Some rise above their own personal agony to share their stories with us, and to teach us about being different and the need for acceptance. Joni truly believes this is her purpose.

> I wouldn't change my life for anything. I even feel privileged. God doesn't give such special attention

> to everyone and intervene that way in their lives. [God] allows most people to go right on in their own ways. [God] doesn't interfere even though [God] knows they are ultimately destroying their lives, health, or happiness, and it must grieve [God] terribly. I'm really thankful [God] did something to get my attention and change me. You know, you don't have to get a broken neck to be drawn to God. But the truth is, people don't always listen to the experiences of others and learn from them. I hope you'll learn from my experience, though, and not have to go through the bitter lessons of suffering which I had to face in order to learn . . . I will be pleased if only one person is drawn to Christ. Even one person would make the wheelchair worth all that the past . . . years have cost. (Eareckson 176-178)

It would encourage my belief in the accessibility of the ideal, the possibility that we, as society, could recognize and accept all people as they are, if I could see the whole world stilling to listen to the words persons with disabilities share. Persons with disabilities do express wisdom and the vision of the ideal which, for them, was purchased at the price of great suffering, at the experience of sudden physical loss. And, I believe, God will smile in heaven if we truly hear their voices . . . voices imploring us to accept their intelligent, active minds which were not paralyzed by the damage to their spinal columns. The advancement towards the ideal human community begins by hearing and learning from the words of those who have experienced a life-changing event. The opportunity to reach this human potential lies in the actions of the able-bodied response to these voices. Which direction will we take? How many savage branches need be rested upon? When will the process and the progression toward the ideal lead us to a point where we can openly embrace this population and all that they have to teach? Isn't that time upon us?

May humanity begin its own healing process. May humanity find it possible to end its prejudices and to accept and to access the minds that remain. As a true community, let us move forward to accept all people as full, contributing members of society. May all of humanity, persons with physical challenges as well as those who are currently, perhaps, able-bodied, move toward the ever elusive ideal realm and accept everyone as they are, with or without physical challenges.

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