INTRODUCTION

Medical and physical rehabilitation of persons with major medical disorders such as spinal cord injury has progressed to the point where normal life spans are expected and physical mobility problems no longer interfere with leading a full life (Mesard, Carmody, Mannarino, & Ruge, 1978). Such advances in medical and physical rehabilitation may be insufficient however, unless accompanied by efforts to facilitate patients’ psychosocial rehabilitation. One study (cited by Morgan, 1972, p. 37) has shown that in a comparison of two very similar spinal cord injury rehabilitation programs, the one that offered an augmented psychosocial program in addition to medical treatment resulted in patients who maintained their hospital-learned physical gains in the first 90 days after discharge. Of the group that received medical treatment only, 50% deteriorated in the same time period.

Psychosocial rehabilitation initially involves a wide variety of cognitive, emotional, and behavioral coping processes enabling the patient to deal with the immediate physical consequences of the medical disorder. Eventually, the person must come to terms with not only the physical...
limitations but also the broader psychosocial implications of the disability. Thus, the final goal of all rehabilitation efforts must extend beyond physical survival and mobility to include helping the patient develop a meaningful, productive style of life and become successfully reintegrated into the larger community. Although most professionals in the rehabilitation field would agree about the importance of psychosocial intervention, there is much ambiguity concerning just what this would entail. Trieschmann (1978), in a recent comprehensive survey of psychological, social, and vocational adjustment in spinal cord injury, has documented the many gaps in our understanding of this process and the few well-designed or evaluated treatment programs that do exist.

Assertive and social skills assessment and training procedures have been a very recent addition to the clinical armamentarium of psychologists working with medical populations, but the need has been emphasized for more than 30 years. Ladieu-Leviton, Adler, & Dembo (1948) discussed the social consequences of a severe physical disability based on extensive interviews with amputees and facially disfigured veterans. These individuals emphasized their embarrassment about being seen in public, misconceptions about their physical limitations, squeamishness about their appearance, spread of emotional affect from the injury to other personal characteristics, and the social rejection they felt.

This chapter will discuss the need for social skills training in those individuals with acute and chronic medical conditions. Using our research program in social skills with spinal cord injured individuals as a guide, we will illustrate the recent attempts to provide empirical assessment techniques and effective treatment modalities for possible use with other medical populations. Although most rehabilitation efforts appear to be aimed at physical improvement, little is known about the relationship between general social skillfulness, ability to manage the social aspects of a specific medical disorder or disability, and ultimate rehabilitation potential and outcome.

COMMON PROBLEMS

In addition to the obvious physical handicaps involved in a physical disability, the newly handicapped individual must learn to deal with a changed social environment (Davis, 1961; Safilios-Rothschild, 1970). This environment can be conceptualized as four different areas: (1) public attitudes; (2) differential behavioral patterns of nonhandicapped people toward the handicapped; (3) special social situations that apply to specific medical disorders; and (4) decreased general assertiveness.

Public Attitudes

Public attitudes toward handicapped individuals are well documented in the literature (Albrecht, Harasymiw, & Horne, 1977;