

Invisible Disabilities: Stigma and Belonging

A Research Paper

Presented to

The Faculty of the Adler Graduate School

In Partial Fulfillment of the Requirements for

The Degree of Master of Arts in

Adlerian Counseling and Psychotherapy

By:

Megan E. Shaw

September 2012

Abstract

This researcher sought to understand the struggles associated with invisible disabilities. Invisible Disabilities are just that, invisible, or unseen by the naked eye. Often, invisible disabilities have negative effects on a person's self-worth and sense of belonging. There is also a stigma associated with a disabled person when one visibly cannot see the disability. The assumption often is if one cannot see it, the suffering must not be that bad. Along with the doubts of the public, internal struggles deepen for the invisibly-disabled person. Mental health professionals must learn how to deal with a client's self-doubt, depression and feelings of inferiority to name a few. The American's with Disabilities Act (ADA) has made strides in acknowledging invisible disabilities. However, positive strides can still be made by the public and helping profession to better serve people with invisible disabilities.

TABLE OF CONTENTS

Abstract.....	2
Acknowledgements.....	5
Introduction and Statement of Purpose.....	6-7
Assumptions	7
History of Disability.....	8-9
Americans with Disabilities Act (ADA) Definition.....	9-10
Invisible Disability: What is it?.....	10-11
Types of Invisible Disabilities	
“It’s all in your Head”.....	11-13
Physical	13-14
Veterans.....	14-15
PTSD.....	15-17
Traumatic Brain Injury (TBI).....	17
Stigma.....	18-22
An Adlerian Perspective	
Inferiority.....	23-25
Holism.....	25
Significance.....	26
Henry T. Stein “Five Fields of Striving”.....	27
Examples of Significance and Inferiority.....	28
Movement.....	29
Belonging.....	29-31

Organ Inferiority.....	31-32
Organ Jargon.....	32-34
Encouragement.....	34
Therapeutic Treatment	
Lifestyle Assessments.....	35
Movement toward a goal.....	36
The Crucial C's.....	36-38
Style of Life/Life Tasks.....	39
Style of Life Tree by Henry T. Stein.....	40
Felt Minus to a Felt Plus.....	41-42
My Personal Story.....	42-45
Summary and Concluding Thoughts.....	45-47
References.....	48-50

Acknowledgments

There are several people who have made this journey through graduate school a possibility for me. I appreciate more than words can say the encouragement that I have received from my family and friends. The most important thank you is to my parents KC and Cynthia Shaw for their unwavering support. Support not only throughout graduate school, but my entire life. Also, my amazing sister Kari Shaw-Akers who inspires me on a daily basis, and my friend Sarah Essen who I couldn't respect or look up to more. Thank you for believing in me. Gary Sandberg and Shelly Davenport provided the most amazing internship opportunity and learning environment for me. They also continue to be mentors and friends and I wouldn't be where I am without them. I appreciate you beyond words.

The Adler Graduate School was the perfect place for me to land as I journeyed into the helping profession. Thank you to my chairperson Dr. Karyl Frye and my reader Sue Brokaw. I knew the minute that I met Dr. Frye that I would want to work with her. Her encouragement and expertise is incomparable. Her hard work and help throughout this process meant so much to me. I couldn't have asked for a better chairperson.

Invisible Disabilities: Stigma and Belonging

“To see with the eyes of another, to hear with the ears of another and to feel with the heart of another” (Carlson, Watts & Maniacci, 2005, p.67).

This researcher sought information from various sources including peer-reviewed journals to accurately articulate invisible disabilities; both physical and mental. The purpose of the research is to bring to light the problems that can be associated with an invisible disability. The main questions that this research is intended to answer are: (1) Does having a disability that cannot be seen by the naked eye effect self-esteem and sense of belonging? And (2) is there a stigma associated with invisible disabilities? Given that, “Well over 74 percent of all Americans live with invisible disabilities” (Adams, Blumenfeld, Castaneda, Hackman, Peters, & Zuniga, 2010, p. 457) a better understanding of the associated impact on those affected can aid therapists who work with this population and inform society of more appropriate ways to approach those who are impacted.

An invisible disability is unseen, something that cannot be seen with the naked eye and is not immediately apparent. According to Sue (2008), a myth surrounding disability is that most use wheelchairs. “Of the 49 million individuals with disabilities, only about 10 percent use wheelchairs, crutches, or walkers. Most have disabilities related to cardiovascular problems, blindness, developmental disabilities, or invisible disabilities such as asthma, learning disabilities, or epilepsy” (p. 488).

The general public has a hard time believing that someone is in pain or has major health issues when their looks say otherwise. Determining the extent of one’s pain, injury or disability cannot be done by just looking at someone. The assumption that because a person looks normal they are able to do normal things can be incorrect. The Invisible Disabilities Association (IDA)

was founded to help those that have invisible disabilities and chronic pain. To help family and friends, co-workers and others understand the extent of their pain or distress. It is highly important for family and friends to be supportive and not second guess their condition. It is important because a person who has an invisible disability may already struggle internally with feelings of self-worth as well as a stigma from society that they should be able to do more than they are doing.

This research is intended to inform and educate individuals on the many disabilities that are often overlooked due to not being visible. It is important for the helping profession to be up to date on what options are available for services in regard to disabilities. It is also intended to tie in the Adlerian principles that everyone needs a place in the world where they feel they fit in and have a sense of belonging. A person with an invisible disability often finds that not fitting in or not having a place creates a sense of turmoil in their life.

Stigma is another area of turmoil for the invisibly disabled that will be covered in this research. As described by Joachim and Acorn (2000), stigma is often described as a mark of shame. In medical terms it means a mental or physical mark. There are times that stigma is caused by fear of the unknown. Some people just do not know how to deal with a person that is different from them or different than the 'norm.'

Assumptions

As a female who suffers from an invisible disability this researcher acknowledges that conclusions and findings may be perceived as biased. This researcher used peer-reviewed data that supports the ideas and thoughts behind this discussion.

History of Disability

Historically, disability was viewed as a deficiency and a person who suffered from one was less than human. Disability was also viewed as a condition that was unable to be changed and caused by a sin. Often when children were born disabled they were disposed of or left to live alone on the streets; some even thrown off of balconies. In the eighteenth century; society attempted to deal with the disabled more concretely, but inhumane treatment continued. They would often be placed in insane asylums or jails (Adams et al., 2010, p. 458).

The medical goal was to cure the disability, get rid of a deformity, fix the body, and/or numb the existing pain of the person who was described as the patient. This thinking and methodology resulted in solutions that were invasive, usually by surgery or drugs, and which required submission from the person with a disability. The view that disabilities are deficiencies that require medical treatment and repair remains pervasive today.

(Adams et al. 2010, p. 458).

Positive change began only after masses of World War II veterans returning from war wounded and disabled spurred the medical field into a movement of rehabilitation rather than putting people into asylums. (Adams et al., 2010, p.458). The 60's and 70's swept in to include civil rights for disabled Americans along with the broader civil rights surge. "This struggle resulted in the passage of Section 504 of the Rehabilitation Act of 1973 and the ADA in 1990, both significant feats protecting the rights of people with disabilities" (Adams et. al, 2010, p. 458).

The history of disability was based on disabilities that were visible to the naked eye. Invisible disabilities were often overlooked. They were more often categorized as someone who was a 'freak' or 'off' or 'weird'. In reality it may have been a veteran with a traumatic brain

injury (TBI), a child with attention deficit disorder or an untreated psychiatric disorder. Adams et al (2010) state, “During World War I, veterans returning from war were diagnosed with “shell shock,” uncontrollable shaking, reoccurring nightmares, and imagined re-enactments of horrific events. Today, these symptoms along with others are categorized as PTSD” (p. 459).

Adams et al. (2010), discuss the wide-range of disabilities in the following statement. “We must understand the broadest sense of the word *disability* and expand beyond the image of someone in a wheelchair or a person with a visual or hearing impairment, in order to recognize that disability is a vast category that includes an infinite number of possible experiences” (p. 457).

Americans with Disabilities Act (ADA)

The American with Disabilities Act (ADA) was signed into law in 1990. The U.S. Department of Justice defines a person with a disability as “a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment” (“ADA,” 2008, p. 1). In September 2008, there was an amendment made to the ADA. They expanded the definition of disability by better defining the terms *substantially limits* and *major life activities*. They added that “learning, reading, concentrating, thinking, communicating and working are now recognized as major life activities” (Adams et al., 2010, p. 459).

They added disabilities in the ADA including mental retardation, hearing impairments or deafness, orthopedic impairments, learning disabilities, speech impairment and other health or physical impairments. Psychiatric disorders that are covered include: major depressive disorder, bipolar disorder, panic disorder, obsessive-compulsive disorder, personality disorders, schizophrenia and rehabilitation from drug use or addiction. Not covered by the ADA include:

sexual behavior disorders, compulsive gambling, kleptomania, pyromania and current substance abuse. (Sue & Sue, 2008, p. 484)

Invisible Disability: What is it?

Often, when one hears someone is disabled they assume they are in a wheelchair or use a walker. “On the contrary, the 1994-1995 Survey of Income Program Participation (SIPP) found that 26 million Americans (almost 1 in 10) were considered to have a severe disability, while only 1.8 million used a wheelchair and 5.2 million used a cane, crutches or walker” (“What Is An Invisible Disability,” 2012, p. 5). That means 19 million Americans fall into the category of the Invisibly Disabled, a staggering amount. To an onlooker the symptoms of an invisibly disabled person are not overtly distinguishable. One cannot visibly see chronic fatigue, severe dizziness or debilitating pain. One cannot observe a hearing impairment or a cognitive dysfunction that limits the daily functions of an individual. The severity-of limitations also vary from individual to individual. Some may have mild challenges and others major limitations. The visibly disabled community also has a stigma that faces them. There are problems associated with both the visibly disabled and the invisibly disabled. There are scenarios where a person who is in a wheelchair is invisible too. They are not seen as a whole person, and often they are ignored. They often have to prove that they are in fact a *whole* person, while the invisibly disabled individual has to prove they actually are sick and not faking their illness. A visibly disabled person has to prove that they are a whole person and that they deserve respect. A good example of this is in the following story.

The airline wheelchair had grime on its wheels and the woman’s jacket got soiled. As if being pushed around in this frenetic airport wasn’t enough, now her new coat marked with oil stains from the chair would be yet another reminder of her inability to walk and

her dependence on a wheelchair. Her loving companion, weighed down by the backpack housing her medical paraphernalia, wove in and out through the gawkers, as he pushed her along. After what seemed like a marathon, they presented themselves at the custom's counter. He pulled out their documents. An expressionless customs officer perused the papers. She spoke directly to him, "Can she stand?" as she pointed to the woman in the wheelchair. The sitting woman hoisted herself up to the counter. She stared deeply into the eyes of the officer and responded, "She can stand, she can hear and she can speak." (Giroux, 2002, p. 21-22).

This example shows that any kind of disability can be judged harshly. Visibly, 'you are not whole', invisibly, 'you aren't that sick'. Who a person is internally, spiritually and emotionally far outweighs if a person is missing a limb or has a learning disability. Giroux (2002) states, "We are a blend, a unified whole. We preserve our unity whether or not we are chronically ill" (p. 23).

Unfortunately, for an invisibly disabled there are the conclusions and assumptions that others may make based only on what they can *see*. They make a decision on what a person can or cannot do based on their sight. "This can be equally frustrating for those who may appear *unable*, but are perfectly capable, as well as those who appear *able*, but are not" ("What is an Invisible Disability," 2012, p. 8).

Types of Invisible Disabilities

"It's all in your head"

Often, the phrase invisibly disabled people will hear is "it's all in your head." This indicates that others do not believe that the person is truly suffering from something. This is a phrase heard from friends, family and even doctors. Some act suspicious and as if they do not

believe the disability is true. The invisibly disabled person then lives with the fear of not being believed. Often they begin to doubt their own symptoms and feel ashamed. Davis (2005) states, “There are many individuals with conditions, illnesses, and structural and biomechanical anomalies that are life limiting but not readily discernible to others” (p. 153). Some examples of these conditions are chronic pain, seizure disorders, fibromyalgia, severe allergies or chemical sensitivities and mental illness. Many experience reactions that are asthmatic and neurological when exposed to perfumes or colognes. Just leaving their home can cause adverse reactions.

Many people can go about their day without pain and discomfort. They can accomplish things without severe exhaustion. This is not always the case for a person suffering from an invisible disability. The quality of a person’s life may be significantly impacted by a condition one cannot visibly see. They may suffer unknowingly to other people. Someone suffering from multiple sclerosis may have to sit down while they are leading a seminar or teaching due to exhaustion. Or, instead of sitting down they may be struggling internally with a large amount of pain, but trying to act as if nothing is wrong. Sometimes this is because they want to protect themselves. They may fear others may not truly believe that anything is truly wrong with them because they look so normal.

Other forms include disabilities like bi-polar disorder, Alzheimer’s disease, post-traumatic stress disorder (PTSD), schizophrenic or dyslexia. These are serious brain disorders that are not visible to the naked eye. Someone may be told to ‘snap out of it’ if they are depressed, or that they should ‘pull themselves up by their bootstraps.’ If someone broke a leg or had a case of appendicitis they would be told they need real help. The same should be true for someone suffering from depression or PTSD. This research will focus on a few different areas

of invisible disabilities. Some will be more associated with mental health and some will be more connected to an invisible physical challenge.

Physical Disabilities

There are numerous physical disabilities that are invisible. Many of them are not able to be noticed by a simple glance. One will not know a person is suffering from Crohn's disease, degenerative joint disease or chronic fatigue syndrome simply by observing them walk into a grocery store to buy milk. When a person is suffering from a physically debilitating disorder that is invisible they often place themselves at risk by trying to do too much. They may set themselves up for a painful reoccurrence or flair up by being too active.

There are numerous physical disabilities that are invisible. One example is fibromyalgia. Some symptoms of this invisible disorder are very tender points in soft tissue in areas like the chest, back, shoulders, back and knees. It is a pain that can be a deep ache, or a shooting or burning pain. The pain isn't visible at all. Another example of an invisible disability is a student's cognitive impairment. This student may have trouble completing school work or organization may be difficult. However, the teachers are not aware of the student's disability.

Grace is a woman who had a traumatic brain injury when she was sixteen years old. She was in a car accident, an all too common occurrence. An accident occurred, her head hits a part of the car and internal damage to the brain results, ranging from mild to severe. Grace shows no outside cues of brain damage. There are no visible cues of her head injury. Grace's walking, vision and physical reflexes look "normal. People look at Grace and assume she is fine and then react to her difficulty as if she is being lazy or choosing to be obstinate. Teachers' judgments of Grace have been based on assumptions made from Grace's physical appearance ("Invisible Disability," n.d., para. 4).

Learning about disabilities that are unseen helps the public understand what many advocates already believe. “The determination of whether an individual human is disabled is not based purely on the biological, anatomical, or functional properties that can be attributed to the individual as such” (Davis, 2005, p. 203). A challenging position for an invisibly disabled person to be in is when they have to point out the fact that they truly have a disability. This puts them in a place of having to defend that their disability actually exists. It also contradicts what most people have known to be true for most of their lives; that you have to be in a wheelchair or using a device of some sort in order to be considered disabled. According to Davis (2005), “It should thus be recognized that people whose disabilities are invisible are regularly put in the position of having to challenge the adequacy of our society’s human paradigm head on, and of having to confront the wall of denial that surrounds and upholds our subscription to this paradigm” (p. 205).

Veterans

Post-Traumatic Stress Disorder (PTSD) is something that is becoming more prevalent in our society today due to the ongoing war overseas. “Currently, over 2.6 million veterans are receiving disability benefits. The number of veterans who are disabled may continue to increase as our foreign wars continue. Survivors often suffer from head, spinal injuries and other injuries” (Sue & Sue, 2008, p. 481). Another war injury that is recognized is the staggering amount of soldiers returning home with the invisible disability of a traumatic brain injury (TBI). These two invisible disabilities, PTSD and TBI have risen dramatically and will continue to rise as the Gulf War and overseas fighting continues.

Sue and Sue state (2008):

Discussions regarding PTSD and TBI are increasingly being brought to our attention as significant numbers of veterans of war are returning with PTSD and mild-to-severe TBI. TBI can result from any type of injury to the brain that causes it to swell, such as artillery fire, car crashes, explosions, and any non-war-related incidents such as sporting activities. The manifestations of TBI include impaired cognition, sensory processing, communication, and mental health, and/or personality changes (p. 459).

Personality changes, mental health and substance abuse issues are also increasing with the return of soldiers. Anxiety disorders, depression, attention-deficient disorder, and narcolepsy are also disorders that effect numerous people on a daily basis that many ignore. All are current issues that mental health practitioners will need to deal with effectively.

Post-Traumatic Stress Disorder

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) describes PTSD as the following: “The person has been exposed to a traumatic event in which both of the following were present: (1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others (2) the person’s response involved intense fear, helplessness, or horror” (American Psychiatric Association, 2000, p. 218). The DSM-IV-TR then goes on to discuss the traumatic event is re-experienced in different ways.

Many of the responses and symptoms that are involved with PTSD and TBI are invisible. Some symptoms of trauma include the following responses. *Re-experiencing* a trauma can include symptoms like flashbacks, intrusive memories, and nightmares. It often feels as if the trauma is actually happening all over again when these symptoms happen. “These symptoms can appear at any time, sometimes seemingly out of the blue. At other times, something triggers

a memory of the original traumatic event: a noise, an image, certain words, or a smell” (National Council on Disability, 2009, p. 15). In fact, brain studies have verified the neurological response of a re-created event is the same physiologically as the actual event. One’s physiology responds the same for each re-lived event as it did in the original event. Thus PTSD sufferers physiologically re-live the trauma over and over again (National Council on Disability, 2009)

The National Council on Disability (2009) also discusses *avoidance/numbing* ways of coping for victims of PTSD. The person may go to extremes to avoid activities or thoughts that remind them of the traumatizing event. “In addition, they may lose their ability to experience pleasure and may seem emotionally ‘flat’ or nonresponsive. They may feel detached or estranged from others” (p. 16). Next, they discuss *hyper-arousal/hyper-vigilance*. This involves a person feeling as if they are in constant danger. “This increased arousal may disrupt sleep, contribute to irritability and anger, and impair concentration. Hyper-vigilance may coexist with an exaggerated startle response” (National Council on Disability, 2009, p. 16).

Having the exaggerated startle response and feelings that the event may re-occur are issues that veterans are trying to cope with on a daily basis. “PTSD symptoms may result when a traumatic event causes an over-reactive adrenaline response, which creates deep neurological patterns in the brain. These patterns can persist long after the event that triggered the fear, making an individual hyper-responsive to future fearful situations (“PTSD,” n.d., p. 8). People who suffer from PTSD suffer from lower cortisol levels and over time this can cause adrenal fatigue, thyroid problems and a lower immune system.

The public cannot see the fact that the veteran is suffering internally. It is invisible. It is not easy to see the amount of stress, depression and anxiety a veteran suffers when they return from war, or the negative effects that it has on his/her family and loved ones. There is a high

level of co-morbidity that comes along with having PTSD. Usually, these are other behaviors, psychological or medical conditions. “Several studies have found that more than 80 percent of people who have been diagnosed with PTSD also have generalized anxiety disorder, social anxiety disorder, major depressive disorder, or one of a range of psychiatric or substance-related conditions” (National Council on Disability, 2009, p. 17). All of these invisible disabilities and conditions reach to other areas of a veteran’s life. Their family life and relationships are affected. They may have issues coping with maintaining a job. Withstanding the stress of PTSD can be a huge hurdle for anyone to conquer. Part of the hurdle is that people do not understand there is a problem if they cannot see it with their own two eyes. They can understand a person is suffering if they can see a lost limb, but cannot ‘see’ a person enduring emotional turmoil.

Traumatic Brain Injuries

Traumatic Brain Injury (TBI) symptoms vary depending on the extent of the damage. According to the National Council on Disability (2009), “...symptoms of mild TBI include headache, confusion, lightheadedness, dizziness, ...a change in sleep patterns, behavioral or mood changes, and trouble with memory, concentration, attention, or thinking” (p.20). What is interesting is that even mild injuries can have a prolonged affect on a soldier’s life after war. Moderate to severe TBI have the same symptoms but are worse, and sometimes permanent. These can include but are not limited to, “...slurred speech, weakness or numbness in the extremities, loss of coordination, and increased confusion, restlessness, or agitation” (National Council on Disability, 2009, p. 20). When these veterans return from war and need care, the fact that the conditions that they are dealing with are unseen makes it harder to ask for and receive help. They often do not get the full treatment that they deserve. Integrating screening for PTSD and TBI into primary care is something that should be addressed moving forward.

Stigma

A myth about disability is stated as follows: “*The greatest barriers to people with disabilities are physical ones.* In actuality, negative attitudes and stereotypes are the greatest impediments and the most difficult to change” (Sue & Sue, 2008, p. 488). Stigma can be a hard thing for anyone to face. No person wants to have a stigma associated with a condition they have. “Stigma comes from a Greek word which describes signs that indicate something out of the ordinary or bad about a person” (Joachim & Acorn, 2000, p. 243). If there is a stigma surrounding a condition one has like HIV, this can cause severe concern for the person with the condition. They can also expect the impact from their community, social life and work place.

Another question is: What is the cause of the stigma? Is it congenital or acquired? This question can make a difference in the feelings that are associated with the disorder or disease. If a person acquires a chronic condition later in life; acceptance of that disorder may be more difficult. Sue & Sue (2008) state the following: “Greatest prejudice is displayed to hidden disabilities such as HIV or psychiatric conditions. As a person with schizophrenia stated, “I don’t want to tell anybody, because people who aren’t ill, do have a tendency to sometimes treat you different...we’ve got to disguise ourselves a lot.” (p. 483). Imagine a loved one suffers from bi-polar disorder. The medication that they take normalizes their moods and they function at a very high level. They are able to hold down a good job, provide for their family and live a good life. However, if anyone finds out that they have a mental illness, some may immediately assume they are crazy. People may start to dismiss things they say assuming they are not important or competent.

There is often a challenge to the invisibly disabled community to prove that they are disabled. Davis (2005), discusses, “the handicapped parking space challenge,” which proves a

clear and succinct illustration of the difficulties of having to face (and overcome) this challenge.” (pg. 211). A handicapped parking space is granted by an official and medical professional. This gives the go-ahead to use the accessible parking. An invisibly disabled person faces the possibility of parking there and walking into the store just to be accosted by a vigilante who needs to explain to them those spaces are reserved for ‘real’ handicapped people. “As many can attest, when people with invisible disabilities park in a “handicapped” parking space, they may be accosted by strangers who feel entitled to quiz them about why they are parking there, since they are “obviously not handicapped” (Davis, 2005, p. 211).

This judgment and assumption is not only incorrect but places a large amount of stress on the disabled individual. They are in a constant feeling of having to prove that they are truly disabled. They are viewed as cheating the system. They are judged unfairly and harshly. This takes a huge toll on a person. Davis (2005) discusses,

It is also profoundly counterproductive to be repeatedly exposed to hostile challenges.

Many conditions are far more activity restricting, far more unpleasant, and potentially far more health compromising when a person is forced to dwell on his or her symptoms and pushed into exaggerating them...To “prove” that they are disabled, those with invisible disabilities are often compelled to focus attention on their problems. But doing this can exacerbate the problems, intensify their suffering, and augment their disability (p. 212).

Having to consistently prove a disability exists can be an added stress that can also be detrimental to a person’s health. To get special privileges that the ‘real’ disabled people are given; they have to show extra proof that they are disabled. They have to almost make a case of proof. It becomes an easier task to act as-if they are not disabled. It is easier to put themselves in danger and risk, just to act as-if they are perfectly fine. “Those whose disabilities are invisible

will often have more motivation to “pass” than to “come-out.” which may imperil their well-being, exacerbate their disability, and deepen their invisibility” (Davis, 2005, p. 212). The person will not park in the assigned spot causing more harm to their physical condition.

Some do not take into consideration that having a condition like chronic fatigue syndrome (CFS) causes a person not to have enough energy to park far away. If they do park a far distance to avoid stigma they are causing more harm to themselves. Davis states (2005), “They thus face a double-bind: either forgo the assistance or accommodation they need and thus suffer the consequences of attempting to do things they may not be able to do safely by themselves, or they endure the discomfort of subjecting themselves to strangers’ interrogations” (p. 155). Anyone who has a disability, be it a visible or an unseen one, needs to have things to help them deal with life safely. Their life can be at risk if they do not get the assistance that they need and deserve.

Imagine a man walks into a room, who has problems with pain and sensation in his feet. The problem is that his feet are mostly numb so he has balance issues. Yet, he looks completely normal. However, because he has this disease of the nervous system (neuropathy), he gets tired very easily and is in constant pain. Someone else walks into the room very quickly and bumps into him. Most people would just stumble a little and catch their balance just fine. But because this man cannot feel his feet and cannot catch himself he falls to the ground. This causes major embarrassment for him and he feels as if he has been found out. There is something not right with him. Everyone is staring; most probably thinking he is just drunk because they still cannot see that anything is actually wrong with him. Before the fall happened, everyone thought he was completely ‘normal’; but now people know that he is different. However, they still may not know that he is suffering from an invisible disability.

Many people who suffer from an invisible disability will attempt to act normal. They may minimize the true effect of their stigmatizing condition. Some may do this by joking about their condition, which is a type of covering technique an invisibly disabled person may utilize. “If the signs of the stigma are invisible to others, the individual is discreditable, but not yet discredited” (Joachim & Acorn, 2000, p. 243). They may try to pass as ‘normal’ by not disclosing their condition, they may face further stigma, but then the worry is there for them that people will think they are lying if they conceal the condition. This threat of discovery often forces a person to try to pass as normal. Joachim & Acorn (2000) state, “passing involves deliberate concealment, and differs from covering, where the intent is to downplay a condition” (p. 245). Deliberate concealment is when a person really wants to fit in with their peers and not stand out. This can cause the person to feel bad about lying to others. They may have issues morally with lying about it. The problem with this can be that a person could be caught in a lie as well. It would be unintentional to lie to people, but that concealment will cause them to have that constant risk and worry about being discovered and found out.

If a person acquires a chronic condition later in life; acceptance of that disorder may be more difficult. The problem they face can be finding a new normal that suits their lifestyle. They may have lived a healthy and fulfilling life and their circumstances have not changed. That is not to say a person cannot live a full life with a disability. However, being healthy and then having a life change health-wise can have a significant affect both mentally and physically.

Some may think that because the visibility isn't there, the stigmatization is also less. This is a matter of opinion, but the fact that people with invisible disabilities have to tell and re-tell their stories over and over again is often re-traumatizing. The fact that it is invisible also makes it harder to get assistance for certain things that may be needed. There is a certain amount of

convincing that needs to take place because they do not look disabled. Emotionally, this can take its toll. Having to constantly convince others that in fact one is sick can be exhausting. An invisibly disabled person may be unfairly judged for getting services others think they do not need. They may be viewed as getting an advantage and it is seen as unfair.

There are three types of stigma discussed in the National Council on Disability (2009) article that pose barriers to people seeking treatment. They include the following:

Public Stigma refers to the public (mis)perceptions of individuals with mental illnesses. Over half surveyed soldiers who met criteria for a psychological health problem thought they would be perceived as weak, treated differently, or blamed for their problem if they sought help.

Self Stigma refers to the individual internalizing the public stigma and feeling weak, ashamed and embarrassed.

Structural Stigma refers to the institutional policies or practices that unnecessarily restrict opportunities because of psychological health. Service members repeatedly report believing that their military careers will suffer if they seek psychological services. They believe that seeking care will lower the confidence of others in their ability, threaten career advancement and security clearances, and possibly cause them to be removed from their unit (p. 51-52).

Early intervention and available resources are highly important when treating PTSD and TBI for returning veterans. Making known that the invisibly disabled suffer the same amount as a troop who has lost a limb is a step that needs to be overcome as well.

Alfred Adler

“To be human means to feel inferior” ~Alfred Adler

Inferiority

Some synonyms for the word inferiority are deficiency, inadequacy, mediocrity and weakness. Striving to be anything but inferior is where people want to be. It is important to remember one can be enough and have abundance even with having an invisible disability. Ansbacher & Ansbacher (1956) state, “Each individual strives from a feeling of weakness and inferiority, as this is shown also in bodily development, towards a goal of an ‘ideal end-form,’ that is, toward overcoming all difficulties of life” (p. 254). Alfred Adler discusses the useful side of life and developing social interest. This can only be done if an individual values self. Adler’s theory speaks about inferiority being a human condition that we are all born with. We are all born feeling inferior and are striving to beat the deficiencies that we are born with. “Inferiority feelings are those universal human feelings of incompleteness, smallness, weakness, ignorance, and dependency included in our first experiences in infancy and early childhood. Inferiority feelings continue to be experienced to greater or lesser degree throughout adult life” (Griffith & Powers, 2007, p. 60). These deficiencies are that we are helpless and weak when we are born. This struggle is what Adler called *striving for superiority*. This striving is the driving force behind all human emotions, thoughts and behaviors.

Feist & Feist (2009) found the following:

Adler insisted that the whole human race is “blessed” with organ inferiorities. These physical handicaps have little or no importance by themselves but become meaningful when they stimulate subjective feelings of inferiority, which serve as an impetus toward perfection or completion. Some people compensate for these feelings of inferiority by

moving toward psychological health and a useful style of life, whereas others overcompensate and are motivated to subdue or retreat from other people (p. 69).

Living with an invisible disability causes a constant feeling of inadequacy. There are daily physical challenges. One thing that Adler did was turn negatives into positives. He believed that when one has the desire to be better and overcome they have something to strive for. Inferiority feelings are a normal experience for all humans. When the feelings of inferiority begin it seems that then humans strive for improvement. When one does overcome the negatives in life it can create courage and self-respect. When issues in life come up that are surrounded by disappointments, worry and life pressures, it most always is within the box of inferiority feelings. This inferiority can cause many emotions or states of mind which the average person knows to be shame, depression, anxiety or other emotions (Ansbacher & Ansbacher, 1956).

One can have feelings of inferiority and also an inferiority complex. All people suffer from feelings of inferiority from the day they are born. However, when it becomes a problem in a person's everyday life and affects the level of functioning it turns into an inferiority complex. "We say that a person is suffering from an 'inferiority complex' when he reacts fatalistically to a crippling situation, real or fancied, without attempting to correct or improve it (Slavik & Carlson, 2006, p. 354). Usually it is when a child is young that they are seen as inferior and physically weak. If someone does not dismiss this belief and explain to the child that this is in fact not true, they will develop an inferiority complex that he/she may carry throughout life, regardless of how successful they are in life. "Since the feeling of inferiority is generally regarded as a sign of weakness and as something shameful, there is naturally a strong tendency to conceal it" (Ansbacher & Ansbacher, 1956, p. 119). This is a very natural reaction especially with a person

suffering from an invisible disability. Because of the perceived weakness by others they doubt themselves and act as-if they are ashamed of their condition.

Holism

In 1929 a man by the name of Jan C. Smuts coined the term “holism.” The first person to appreciate Smut’s work was Alfred Adler. “Smuts spoke of personality as fundamentally an organ of self-realization with a meaning similar to self-actualization or self-transcendence...” (Ansbacher, 1961, p. 486). One of Adler’s goals was for people to have a holistic view when it came to psychology. Being whole to many means unbroken, not less than or of intact state. People living with chronic challenges are often in a feeling of brokenness (Giroux, 2002, p. 21). Unfortunately, many people view a person who has a disability as less than. Giroux (2002) discusses how Adler through trying to find meaning in his own life and through helping others placed an importance on the whole of the individual.

Louise Giroux was diagnosed with Multiple Sclerosis at the age of 36. After she was diagnosed, all of her needs in regard to technical things were taken care of. Meaning, she had mobility aids, pills, grab bars for the bathtub, and a raised seat for the toilet. While her technical needs were taken care of, none of her psychological or emotional needs were mentioned. The holistic approach is not often taken, which means treating the body as a whole, the mind, body and spirit. Many health-care providers think that if we treat the body it will also treat the rest of us. This is not the case. Many of them see far better results by having a holistic approach than they do just laying there having no visitors while they try to heal. “When the body breaks, the mind and the heart also break since we are a package deal” (Giroux, 2002, p. 25).

Significance

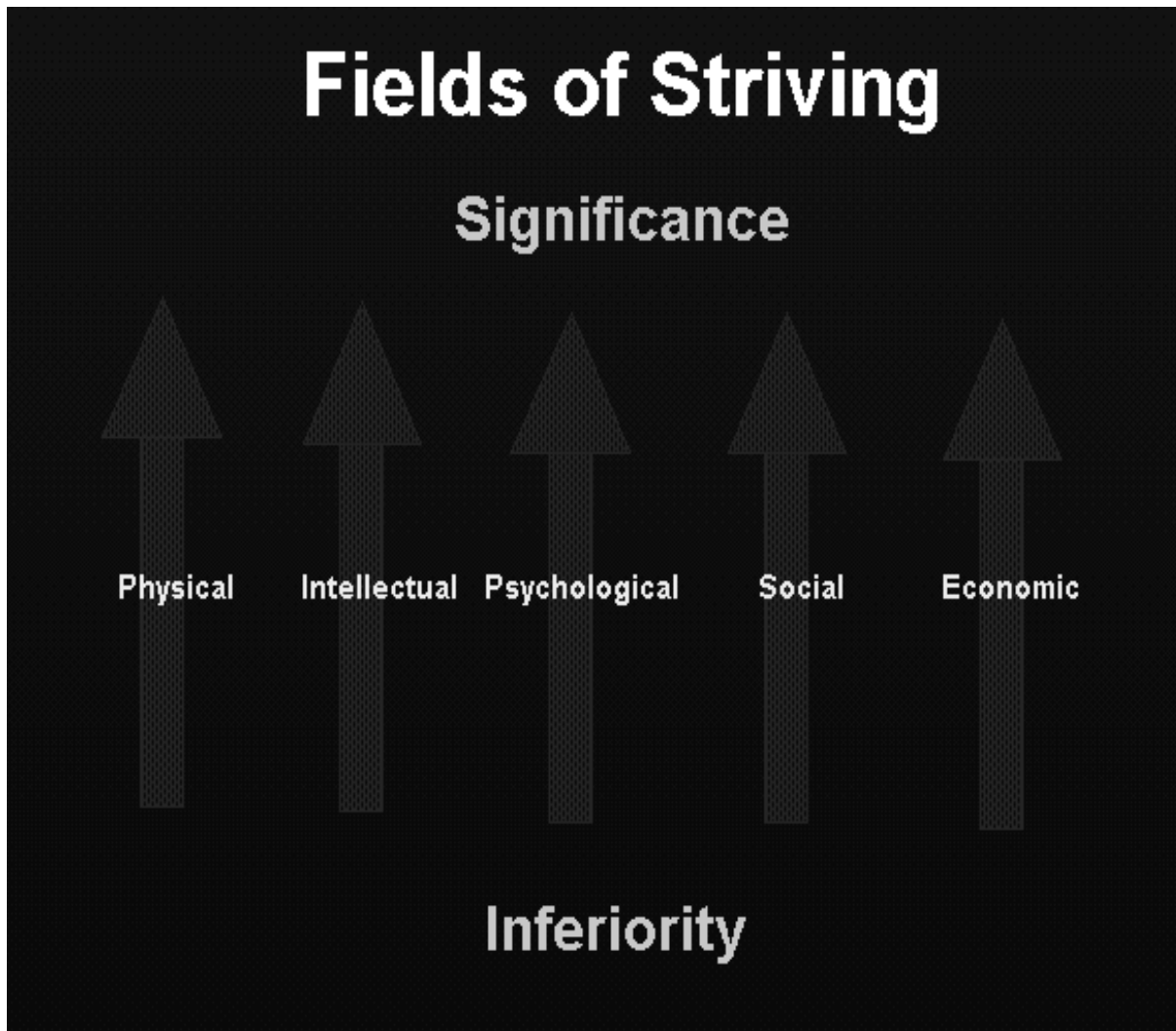
Human beings yearn to matter and have significance. Adler talks about striving for significance from the moment that we are born all the way until we die. The significance that we all strive for defines who we are. When we have no significance we feel we have no meaning. Living with an invisible disability can often do this.

...I'm just an insignificant bug

Every acquaintance and friend she knew was going to work today, launched into fall, after Labor Day. They carried lunches and brief-cases. Her children wore their new outfits and toted new notebooks, unsharpened pencils and had mostly butterflies in their stomachs. At the crack of dawn, the closing of her husband's lunch box had echoed that he was leaving for work as usual. She remained sitting by the window as the rest of the world engaged in living, she experienced herself as less than she had ever been. "I have lost all significance, I have no meaning, I am nobody (Giroux, 2002, p. 28).

This can be viewed as a feeling of being insignificant and lack of self-esteem. Yet, a person suffering from an invisible disability that is having a rough day due to chronic pain is suffering. Suffering from a condition that is constant makes a person feel consistently isolated because of being sick or unable to do things. Striving for significance, in a true Adlerian's view would be seen as a very large part of the human existence.

Henry T. Stein, Ph.D. (1997) from the Alfred Adler Institute in San Francisco, California developed a way to look at striving for significance and the areas at which the human race does this. This is based on Anthony Bruck and titled, "The Five Fields of Striving for Significance."



EXAMPLES OF INFERIORITY AND SIGNIFICANCE

<u>FIELD</u>	<u>INFERIORITY</u>	<u>SIGNIFICANCE</u>
<u>PHYSICAL</u>	Organ Deficiencies, Physical Handicaps, Deformity, Ugliness, Weakness, Abnormal Height or Weight, Sickness, Severe Hunger or Thirst, Sexual Frustration	Strength, Beauty, Athletic Ability, Good Health, Sensory Pleasure, Sexual Gratification, Physical Closeness
<u>INTELLECTUAL</u>	Ignorance, Illiteracy, Feeling Stupid, Lack of Skill, Difficulty in Learning, Boredom	Knowledge, Understanding, Skill, Artistic Ability, Academic Success, Enjoyment of Music, Art, Drama, and Literature
<u>PSYCHOLOGICAL</u>	Negative Character Traits (Real or Imagined), Feeling or Acting Crazy, Disliked or Hated, Ashamed of Oneself, Feeling Bad or Guilty	Positive Character traits, Proud of Oneself, Liked by Others, Admired by Others, Loved by Someone, Self-Actualizing
<u>SOCIAL</u>	Being Alone, Isolated, Being Excluded, Not Invited, Abandoned, Socially Awkward	Contact With Others, Membership in Organizations, Identifying With Group, Socially Adept, Social Acceptance & Approval
<u>ECONOMIC</u>	Poverty, Financial Distress, Underpaid for Work, Loss of Job, Not Keeping Up With Norm, Losing Money	Good Income, Paid Well for Work, Financial Security, Wealth, Getting a Raise in Salary, Winning the Lottery

Developed by Henry T. Stein Ph.D. (1997)

Movement

This quote talks about movement and Adler has stated to trust only movement.

Life is movement. We can be driven or we can drive. We can take the backseat or the driver's seat. It's all up to us. Life's movement consists of two energies: its own and ours. Chronic illness happens: that life's movement. We choose how we will live with illness; that's ours. It's a dance we learn, we practice and we eventually master. But, always, it remains our choice (Giroux, 2002, p. 174).

Adler (1958) discusses movement and how it is that striving towards a goal that causes the movement. He states, "All our strivings are directed towards a position in which a feeling of security has been achieved, a feeling where all the difficulties of life have been overcome and that we have emerged finally, in relation to the whole situation around us, safe and victorious" (p. 27). He also discusses the joining of body and mind in unity. The body tells the mind that it must become whole again forcing one into action to make that happen.

The mind is like a motor, dragging with it all the potentialities which it can discover in the body, helping to bring the body into a position of safety and superiority to all difficulties. In every movement of the body, in every expressing and symptom, we can see the impress of the mind's purpose. A man moves. There is meaning in his movement (Adler, 1958, p. 29).

Belonging

People who have disabilities and chronic conditions often have to adhere to a strict management of their lives. They may often worry about that piece of being discredited when someone else notices they have something wrong with them. This can cause difficulty in social relationships. This may be why some who suffer isolate themselves at times. There are

psychological implications as well as physical ones. Depression may set in and the isolation can cause problems on many levels. It can hinder a person's whole existence. They may have contact with people, but it is not a substantial type of contact. They are often missing the deep and meaningful relationships that human beings crave and need.

When a person who has a disability tries to hide their disability they are still in search of a place to belong. They feel alienated and cut off from other groups. Even if they are fitting in with the 'normal' group of people, they still know they are different. They may not have that perfect place to fit. That perfect place where others truly understand the angst and pain that may be involved in having an invisible disability. This is where finding more types of support can be quite helpful.

Going to a doctor may even be a source of anxiety for someone struggling with an invisible disability. Sometimes their healthcare provider may even think that they are malingering by trying to get some sort of secondary gain by pretending they have an issue. This judgment is very hurtful to the person suffering. "Those who fail to conform to those standards are not literally invisible, but they are marginalized; they are socially invisible" (Davis, 2005, p. 190).

One area of research was based on an article called *Invisible Doesn't Mean it Isn't There* by Keith L. Swenk (2012). It was based on a man who has Multiple Sclerosis. He spoke about the numerous times that he would have to disclose his illness and how it brought a churn to his stomach each time he had to disclose.

In his article Swenk (2012) explained the following:

Just because we can't see the need doesn't mean it is not there. This article is for the student who can write page after page of beautiful prose but can't add 2 + 2. This article

is for the student who can memorize Pi to the 20th place but can't tell time. This article is for the student who can name all the states and their capitals but can't remember to bring their lunch to school or to hand in homework or permission slips. This article is for the student who can tell you wonderful stories but cannot put them down on paper. This article is for all of the students that suffer invisible disabilities (p. 5).

The statement made above is quite intense. Everyone is touched and knows at least one person who has had to deal with an invisible disability. It can be a struggle for all who are involved, the disabled individual as well as the people who love them.

Organ Inferiority

A central idea that formed along with Alfred Adler's growth was the term Organ Inferiority. Organ inferiority is a condition when a bodily organ doesn't develop normally. This can result in a person overcompensating or compensating. Compensation is healthy for a person while, over compensation can result in an inferiority complex, which is unhealthy (Ansbacher & Ansbacher, 1956).

Adler used this term to describe structural malformation of a specific organ or group of organs (Adler, 1964). He linked the ideas of compensation when one is born with one area that is a malformation. If a child is born with only one leg, they will compensate and make the other leg stronger. Individual psychology speaks of areas of compensations. Adler states (1998), "We have seen that those organs of our body that are essential for life seem to become over-productive when their normal function is impaired by illness or injury (p. 64). This is when one's body takes over and compensates for things that are not functioning well. Adler (1998) also discusses that our psyche operates in the same manner. When our psyche is under pressure

or helplessness it does all it can to overcome, finding other ways of striving to overcome the inferiority (p. 64).

Ansbacher & Ansbacher (1956) found:

Children born with inferior organs experience their bodies and its pains and weaknesses as a burden. They, much more than normal children develop inferiority feelings, strive to compensate these lacks and to arrive at a goal in which they foresee and presume a feeling of superiority. In this movement from below to above, from a felt minus to a presupposed plus, they are attached much more by the difficulties of life and feel and live as though they were in an enemy country. Fighting, hesitating, stopping, escaping, much more occupied with their own persons than with others, they are therefore selfish, inconsiderate, lacking in social interest, courage and self-confidence because they fear defeat more than they desire success (p. 118).

Organ Jargon

“Sometimes the mouth lies or the head does not understand; but the functions of the body always speak the truth” ~Alfred Adler

“One child will grow up in a situation so complicated that she is bound to make mistakes about the degree of her inferiority. Another child will be better able to interpret her situation” (Adler, 1998, p. 65). The concept of ‘organ jargon’ helps provide a way to understand clients who have symptoms that are physical (Griffith, p. 437). In conjunction with the above quotation, the body always tells a person what is going on. The body responds to a situation or symptom when our mind or words are not able to (Griffith, p. 437). The idea is to understand one’s own physical speech as ‘organ jargon.’ Some examples of organ jargon and body-related metaphors

can help provide a clue and assist therapists in finding the deeper seeded issues. Jane Griffith (1984) describes the following metaphors:

aching arm: I have such a burden. I'm his or her right arm. I'm carrying too much of a load

aching shoulders: I carry the world on my shoulders. I'm shouldering too much.

acne: I want to break out. I can't face it. I'm boiling over

allergies: I'm so sensitive. I'm too rash. I can't tolerate any more. I've reached my limit on what I can stand.

anorexia: I have no appetite for it. I can't choke it down. You can't force it down my throat.

arthritis: I can't stand it. I'm freezing up. I'm rigid. I can't bend on that. I can't change. I can't give up my position. I'm hardened to the situation.

bowel irritation: I'm full of shit. I want to get free of this. I want to get clean or clear of this. It's a pain in the ass.

constipation: It turns me off. I don't give a shit. I'm shut out. I'm uptight about it. I won't yield on this. I won't give myself up to this. I won't give of myself.

inattention, agitation: I'm strung-out, scattered. I can't get myself together. I've got to get going. I can't sit still for it.

stumbling, clumsiness: I can't stand on my own two feet. Don't lean on me. Don't count on me. I can't find my way (Griffith, 1984, p. 441).

Using organ jargon in therapy can keep a situation light. Each 'organ jargon' is unique to each client and their own symptom. Griffith (1984) suggests prompting a client when working with 'organ jargon.' Giving them sentence stems: "it's like..., it's as if....it makes me feel..."

(p. 442). Sometime's a therapist's role is to discover what is under the organ jargon. What is the deeper problem?

Often there is a safeguarding tendency that also falls into play here. Each person has a place in their family or life, and if they get sick or something comes up, they may be uprooting their family life. Therefore they safeguard against anything that is going on with them, all because their self-esteem is more important to them than their comfort level. "To have a place among others is a primary necessity for our survival during the long period of infancy and childhood. Having a place is, in fact, 'a matter of life and death'" (Slavik & Carlson, 2006, p. 86). Having a symptom can actually come as a way out of something rather than losing self-esteem.

Encouragement

Adlerians considered encouragement to be crucial in the development of human beings and stress the importance of using encouragement in therapy (Watts & Pietrzak, 2000). Adler (2000) stated, "Altogether, in every step of treatment, we must not deviate from the path of encouragement" (p. 442). Encouragement can take on many forms. A professional helper can start by helping a client to see their own strengths. Using active listening and showing empathy are other encouraging places to focus, evoking resources within the client and resources the therapist can assist the client find.

Another area of encouragement is the using of group therapy and finding others that are living with similar life experiences. The feeling of not being alone can have a significant impact on a struggling individual. Giroux (2002) describes, "Whether through the mirroring of another, or through our own coming to terms with our own imperfections, we can redefine our self-perception as perfectly imperfect humans" (p. 15).

Therapeutic Treatment

Lifestyle Assessments

One Adlerian therapeutic tool is a lifestyle assessment. This assessment is something of a road map helping an individual understand the way they view the world. It also shows the line of movement that an individual is traveling on. The definition of lifestyle is “the subjective, unarticulated set of guidelines individuals develop and use to move them through life and toward their goals” (Mosak & Maniacci, 1999, p. 47). Throughout the first years of life the beliefs about others, one’s own identity, and the world are formed. Views on life are identified and the search for belonging begins. A disability is like any other challenge one would face. Doing the lifestyle assessment is a journey into self-discovery.

Giroux (2002) states, “Our road map, auto created in the first years of life, taking into account our heredity and our family environment, directs our perpetual movement through life” (p. 40). This assessment tool will look at parental relationships, sibling relationships and family constellation. Then it moves into early recollections. The early recollections, once interpreted, will be formed into five statements (They are: I am, Women are, Men are, People are, Life is and Therefore I should). Translating the early recollections will help a person discover the ways in which they author introduction. “...Adler spoke of a current posture towards life. He suggested that our early recollections generate our belief system and explain as well what’s happening in the now, and predict how well we will move through life when it is challenged” (p. 69). By speaking with a client about the strengths that are found in early recollections the encouragement piece can be highly affective. It can also show their ability to cope with a challenge like an invisible disability.

Movement towards a goal

As discussed earlier, Adlerian therapy is about movement; forward movement and striving towards a goal. “Our future-oriented striving moves towards a goal of significance, superiority or success. Chronic illness creates the challenge of finding that significance” (Giroux, 2002, p. 99). Medical conditions can be overwhelming and become the primary issue in one’s life. It can rule every detail of a person’s life. A therapist can help a client look at their invisible disability and help them learn to focus on how to make things better in their life. What things can enhance their life, what attributes have they gained with the experience of the illness they have (Giroux, 2002).

Adler discusses purpose in life and goal-directedness. He states, “A person’s mental life is determined by his goal. No human being can think, feel, wish, or dream without all of these activities being determined, continued, modified, and directed toward an ever-present objective” (Adler, 1998, p. 15). The goal that one is moving towards can be either static or changing. A therapist, if they understand the goal their client has, is better able to understand the way the client expresses themselves. It will also give the therapist insight into which direction the client wants to take their life. This can be a guide for progression in the therapeutic relationship.

The Crucial C’s

There are three things that people need in order to feel good in their life. They are to feel *connected*, *capable*, and that they *count*. If a person feels *connected* they will feel secure and that they belong. The way a baby or child figures out how to fit in the world is based on how they begin their journey into the world and how they learn to feel connected within their own family unit. “Children who develop a positive connection with their families feel secure. This necessary sense of security enables them to reach out and identify with others in a positive way”

(Bettner & Lew, 1990, p. 16). If they feel unconnected, they are insecure and isolated and may seek attention in the wrong ways.

If a person feels *capable*, they feel competent, have self-control and are self-reliant. They will also feel they can care for themselves and are able to handle what comes their way in life. According to Bettner & Lew (1990), “Children grow up in families where they are allowed to test their competencies in a safe atmosphere, without fear of humiliation, are able to believe in themselves and in their ability to solve problems (p. 16). When they feel they are not capable, they will feel inadequate. They may take on an attitude of ‘you can’t make me’ and become dependent, yet also seek power.

The last crucial “c”, is to *count*. To count means, one feels valuable, has significance and can make a difference; “I matter”. “If children feel their contributions to their families are appreciated and necessary, they will feel confident and willing to contribute elsewhere” (Bettner & Lew, 1990, p. 16). If the opposite is true and an individual feels that they do not count, they feel insignificant and may try to hurt back or seek revenge.

Some say that there is a fourth “c” to the crucial c’s. It is *courage*. This is because in order to find the crucial c’s a person must have *courage!* When one has courage they feel hopeful and are resilient. They can pick themselves up and take risks. They are ENCOURAGED. When a person is lacking courage, they feel inferior and give up, possibly using avoidance. They are DISCOURAGED.

Bettner & Lew (1990) also discuss there are other essential skills needed in order for one to successfully fulfill their ‘crucial c’s.’ The first skill is communication. Communication is important because it is expressing feelings clearly, yet also listening to what others are saying. This is highly important in all aspects of relationships, including, familial and working

relationships. If a person does not have the ability to communicate effectively, they may have weaknesses like, dishonesty or the inability to share feelings with others (p. 17).

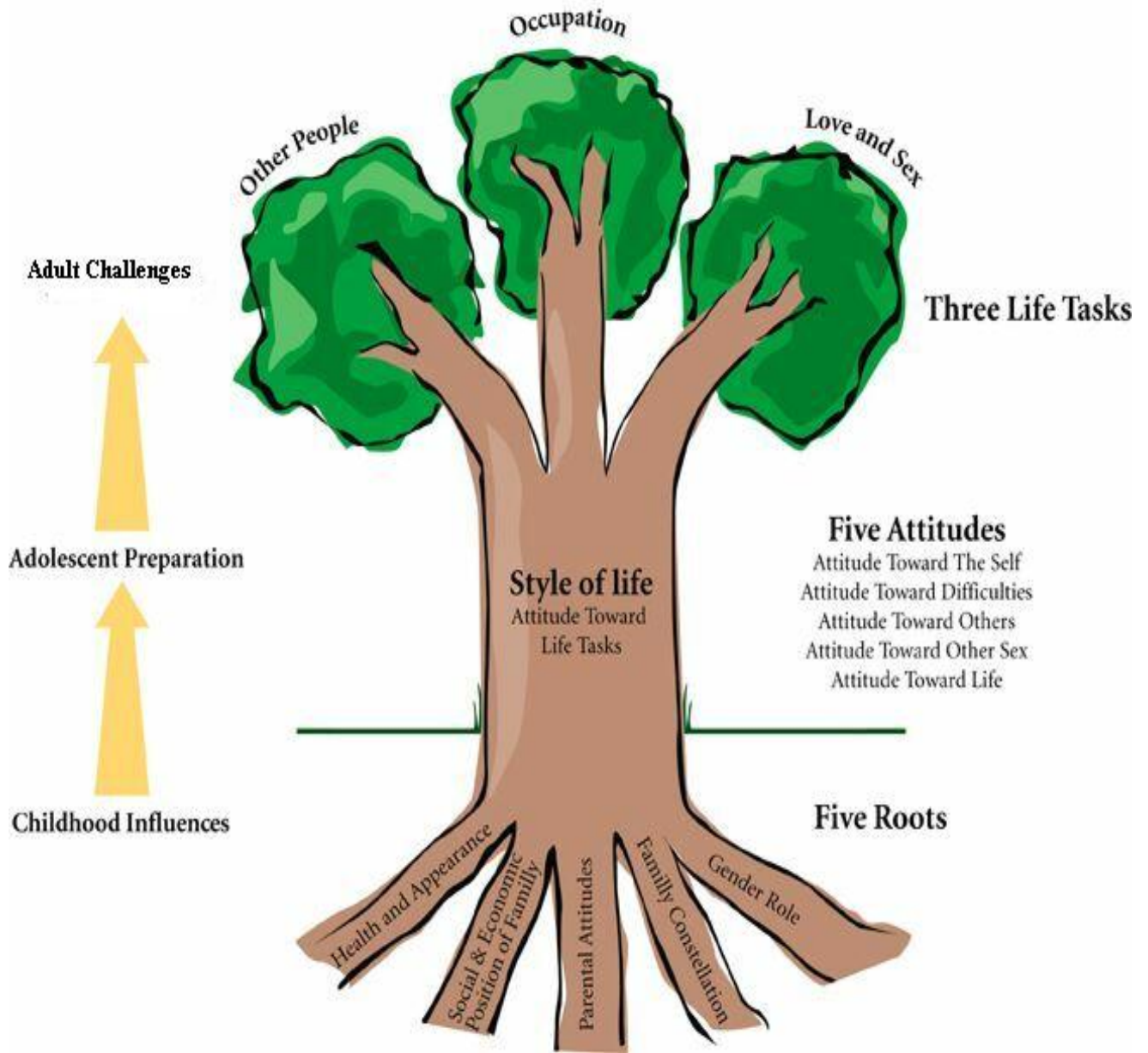
The second skill Bettner & Lew (1990) discussed is the use of good judgment. They state good judgment, "...requires openness to new information the ability to see alternatives, the courage to make decisions and the willingness to evaluate those choices" (Bettner & Lew, 1990, p. 17). If a person does not use good judgment they may find themselves making bad decisions in areas like, drugs or alcohol, financial issues and sex, just to name a few. Thirdly, the ability to assume responsibility is highly important. This includes meeting needs and recognizing limits. The last skill is self discipline. If a person has self-discipline they have a self-understanding and will evaluate their own actions. They are willing to look at their own feelings and attitudes. "Weaknesses in this area result in people who look to others to decide if they are right or wrong" (Bettner & Lew, 1990, p. 17).

This Crucial C's relate to invisible disabilities in many ways. When a person is not comfortable showing their true self, even with imperfections. They feel disconnected. Many times a person with a disability will be isolated. When the disability is invisible, they may not be seen as disabled. Where do they fit? Therefore, who can they connect with? Feeling capable is also one of the crucial c's that is comes to our attention. Capability is being able to achieve what one wants to achieve. Each person in this world is entitled to feel they can achieve the things they put their mind to, that they are competent and significant. Even if someone needs assistance with certain aspects of life, they are still capable and should be treated as such. If one isn't connected with the world in social ways they will isolate and feel disconnected. This is unhealthy and a way that someone who has an invisible disability may cope with their challenges.

Style of Life and Life Tasks

Adler discussed the challenges that adults face in life. He talked about three areas that are highly important to one's mental health. They are what he called *Life Tasks* and they include social (other people), occupation, and love/sex. Henry T. Stein used what he called a Style of Life Tree illustration based on Alfred Adler's model of personality development. The illustration so clearly shows the important areas that are formative in childhood, adolescence and onto adulthood. It creatively helps demonstrate the *style of life* and how it directs our life. Adler discussed how ones *style of life* shows the distinctive approach an individual uses in their life. Some examples could be honest, helpful and consistent or dishonest, exploitative and cruel. Whichever side of the coin an individual falls, it is usually consistently reflected in a person's style of life.

The Style of Life Tree



Developed by Henry T. Stein Ph.D. (1997) | Re-designed by Annie Lalonde (2003)

Felt Minus to a Felt Plus

Individual Psychology talks about inferiority as a baseline human condition. Meaning, humans are constantly striving to be less than inferior but more of an equal with the rest of the human race (Giroux, 2002). Look at the following dialogue to see how one can change from a felt minus to a felt plus.

C: "I've gained 65 pounds since I've started to use a wheelchair. It's awful."

T: "Tell me about your emotional experience as you've made the switch to the wheelchair."

C: "I just don't deal with it, the loss of my mobility and the ability to drive around, It's too much. I don't want to go there."

T: "Is it possible that food has helped to stuff down those feelings of loss?"

C: "I sure have eaten a lot. I suppose food has comforted me."

T: "How creative of you to self-care against your losses. You deemed it just too painful to deal with, so you used your creativity to swallow your pain."

C: "You mean I did OK?"

T: "Well, you certainly are resourceful, to find a way to get through this."

C: "Yeah, but now I'm overweight."

T: "Yes, you now realize some of the negative outcomes of your way of dealing with life these past months. And just like you used your creativity to comfort yourself, we can now make a shift. You undoubtedly can use your creativity to find new ways of dealing with the use of a wheelchair."

C: "OK. I guess I could also use my resourcefulness to get the weight off."(Giroux, 2002, p. 171)

My Personal Story

People have asked why I chose to discuss the topic of invisible disabilities. It was a personal choice for me because I went from living in a normal healthy body to having a debilitating disorder that effects my daily functioning. Therefore, I understand the feelings, stigma and issues with a sense of not belonging in some situations in my own life. Here is my story.

In October of 2007, I woke up with some tingling in my feet and knees. It seemed odd, but I thought it would just pass. I ran to the store a couple hours later and when I returned home I stepped up onto the stoop and my legs gave out beneath me. I thought, "Well that was odd, maybe I'm just really tired." I didn't think anything could possibly be seriously wrong. Then a few hours after that instance I sat down on the couch and could barely get back up to my feet. My strength had completely left me. This is when I got scared. My family called a friend of ours who is a doctor and discussed my symptoms with him. His words were, "you need to take her to the emergency room immediately.....it sounds like it could be Guillain-Barré Syndrome." No one in my family had ever heard of that disease before, little did I know it was going to take my body hostage in a matter of hours.

After the conversation with our doctor friend we had the task of getting me to the ER. I couldn't walk and lived in a split-entry home. I was in the basement, and I couldn't stand or walk by this point. So, my dad and my brother got me to the bottom of the staircase and set me on my rear-end. Then my brother got behind me and with his arms wrapped around me, they together hauled me up the stairs one at a time. Got me onto a rug and pulled me to the door

where they could get me into the vehicle. Now that I think about it, I suppose we could've called an ambulance, but still, we truly didn't think it was *that* serious, maybe just a fluke of some kind.

When we got to the ER, they admitted me immediately to run numerous tests.

Apparently, this disease I kept hearing about Guillain-Barré Syndrome (GBS) spread quickly and was life threatening. Well, this sounds serious and scary (I thought). A doctor (with NO bedside manner) came in and threw a bunch of pages on the bed and said "Well, this is what we think you might have." I picked it up and the first line I read was, "could be on a ventilator."

Needless to say, I panicked and knew this was serious. They did a spinal tap to check spinal fluid; they did an EMG to check my nerve function in my arms and legs. By this time my hands were also going numb. Here is the National Institute of Neurological Disorders and Stroke description of Guillain-Barré Syndrome.

Guillain-Barré syndrome (GBS) is a disorder in which the body's immune system attacks part of the peripheral nervous system. The first symptoms of this disorder include varying degrees of weakness or tingling sensations in the legs. In many instances the symmetrical weakness and abnormal sensations spread to the arms and upper body. These symptoms can increase in intensity until certain muscles cannot be used at all and, when severe, the person is almost totally paralyzed. In these cases the disorder is life threatening - potentially interfering with breathing and, at times, with blood pressure or heart rate - and is considered a medical emergency. Such an individual is often put on a ventilator to assist with breathing and is watched closely for problems such as an abnormal heart beat, infections, blood clots, and high or low blood pressure. Most individuals, however, recover from even the most severe cases of Guillain-Barré syndrome, although some continue to have a certain degree of weakness ("Guillain-Barre," 2012, para. 1).

After the diagnosis I spent one week at the hospital and then was transferred to Abbot Northwestern / Sister Kenny Hospital for Rehabilitation. I had to learn to walk again. I had to strengthen my legs that didn't know how to function any longer. I needed to strengthen my ankles that could no longer hold me. I spent about 4 months in a wheelchair, then graduated to a walker using braces on my lower legs to support my ankles and feet since I had foot drop. Then later on I graduated to a cane....a lot of physical therapy and time and I was walking again with just orthotics in my shoes.

So, what is the link to my story and invisible disabilities? The fact that now I am walking with a normal gait, people think I must be completely better and healthy again. The truth is; my feet are still numb and can't feel much sensation or temperature. It constantly feels like there are pins and needles in my feet because I have peripheral neuropathy. My stamina is very low. My balance is horrible and if there is not a railing to use, stairs are terrifying for me. If it is crowded and I can't see with my eyes where I am walking I get dizzy and lose my balance because I can't 'sense' where I'm moving and standing. I need to use my eyes to compensate for the lack of feeling in my feet. If someone turns the lights out, I get dizzy or fall over because I can't sense where my feet are. If it is cold out, my hands and feet hurt horribly because my nerves are so sensitized. I can't walk barefoot because the pain is too much if I stand on anything other than soft carpet. Oh, and flip flops....forget it! I can't flex my toes and they just fly right off my feet.

So, with all of these issues, where do I belong? That question was very hard for me after I got sick. I had to find a new normal. I really figured out what was truly important in life. Adler's words of having the courage to be imperfect resonated with me beyond belief. I had many lonely days, but also days of great accomplishment. I was terrified many days, but tearfully grateful others. I am continually getting better every day and will continue to do so. I

will always have residual results and symptoms that will be invisible to the rest of the world. I will live with them, knowing that I am not lazy just because I need to use the elevator for one flight of stairs some days. I will live with my symptoms knowing that I am not less-than because I can't do everything a 'normal' person can. One thing I can do is make others aware of the fact that there are numerous other invisible disabilities the people suffer from, and you can't always judge a book by its cover. One should really get to know someone before you assume something about them. I felt called to make more of my life, to show others great things are possible. One can still belong even with an invisible disability.

Summary Statements and Concluding Thoughts

This researcher sought to look at the relationship between invisible disabilities, stigma and sense of belonging. The original research question was, "Does having a disability that cannot be seen by the naked eye effect self-esteem and sense of belonging; and is there a stigma that goes along with it? The initial goal of looking into this topic was to learn more about the topic itself and to find out if the general public had a clear understanding of what an invisible disability is.

There are definite limitations in research done on invisible disabilities. There is a lot of research done on visible disability in general, but not on disabilities that are hidden. This area needs to be expanded in order for the general public to have an understanding about it. It is highly important that this education happens. There are people struggling consistently with the stigma that goes along with a disability, especially an invisible disability.

An Adlerian approach is a perfect fit for invisibly disabled individuals. It is described often as a common-sense approach to therapy. According to Giroux (2002), "The Adlerian approach, invites us to explore who we have become, to define our self-view and our world-view

and, most importantly, to un-earth the unique strengths we bring and utilize to meet the challenges in our lives (p. 13).

The ADA has done a lot for the disabled community, but could continue to do more in regards to invisible disabilities. It is a step in the right direction that they acknowledge and have added to the major life activities like learning, concentrating, thinking and reading. Adding some mental health disorders and learning disabilities also show that the ADA is taking invisible disabilities seriously. The encouragement of the general public learning more would be highly advised.

The population that suffers from invisible disabilities suffers with numerous areas. A person with an invisible disability is seeking dignity and equality, just like all other human beings. Not only that, but they are seeking to be believed about their condition. Wanting to be understood is a problem within the invisibly disabled community. It doesn't only stop with the public, but as stated earlier. This is a problem that can sneak even into the friends and family circles. This feeling of not being believed adds to the stress, anxiety and turmoil an invisibly disabled person is already feeling.

The stigma is also a very large topic with the invisibly disabled community; the stigma that they are just using the system and are not trying hard enough to get better. There is not an understanding that the person who is actually disabled may be mourning the life they used to have as a fully able bodied person. The adjustment that a person who has led a "normal" life has to make is very big. Many struggle with anger and shock if they are given a diagnosis like Multiple Sclerosis or Parkinson's. They may feel as if their body and life have been invaded and will never be the same again. Some may end up having an emotional shut down as a way of protecting themselves. It is an emotional cushion when the turmoil is just too much to cope with.

Adlerian therapy is a very good fit with Invisible disabilities in regard to a therapeutic approach. Looking at the resources that one already carries within them and looking into their private logic and family constellation are important. Giroux (2002) states, “Life, whether with chronic illness or not, is about movement, challenge and change” (p. 8).

References

- Adams, M., Blumenfeld, W. J., Castaneda, C. (Hackman, H. W., Peters, M. L., & Zuniga, X. (2010). *Readings for diversity and social justice* (2nd ed.). New York, NY: Routledge.
- Adler, A. (1958). *What life should mean to you*. New York, NY: Capricorn Books.
- Adler, A. (1964). *Social interest: A challenge to mankind*. New York NY: Capricorn books.
- Adler, A. (1979). *Superiority and social interest: A collection of later writings* (3rd Rev. ed.). New York, NY: Viking.
- Adler, A. (1998). *Understanding human nature*. Center City, MN: Hazelden Foundation.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.
- Americans with Disabilities Act Questions and Answers. (2008). Retrieved from <http://www.ada.gov/cguide.pdf>
- Ansbacher, H. L. (1961). On the origin of holism. *Journal of Individual Psychology*, 17, 486-492.
- Ansbacher, H. L., & Ansbacher, R. R. (1956). *The individual psychology of Alfred Adler*. New York, NY: Harper & Row
- Bettner, B. L., & Lew, A. (1990). *Raising kids who can*. Newton, MA: Connexions.
- Carlson, J., Watts, R. E., & Maniaci, M. (2005). *Adlerian therapy: Theory and practice*. Washington DC: American Psychological Association.
- Crastnopol, M. (2009). Coming to terms with invisible disability-beyond empathic resonance: Commentary on paper by Lauren Levine. *Psychoanalytic Dialogues*, 19, 474-479.
doi:10.1080/10481880903088617
- Davis, A. N. (2005). Invisible disability. *Ethics*, 116 (1), 153-213.

- Feist, J., & Feist, G. J. (2009). Psychodynamic Theories. In *Theories of Personality* (7th ed., pp. 64-96). Retrieved from http://highered.mcgraw-hill.com/sites/dl/free/0073382701/600511/feist7_sample_ch03.pdf
- Giroux, L. (2002). *Making good use of illness: An Adlerian approach to chronic illness*. Dubuque, IA: Kendall Hunt.
- Griffith, J. (1984). Adler's organ jargon. *Individual Psychology: The Journal Of Adlerian Theory, Research & Practice*, 40, 437-444.
- Griffith, J., & Powers, R. L. (2007). *The lexicon of Adlerian psychology* (2nd ed.). Port Townsend, WA: Adlerian Psychology Associates.
- Guillain-Barre Syndrome. (2012). Retrieved from http://www.ninds.nih.gov/disorders/gbs/detail_gbs.htm
- Invisible Disability. (n.d.). In *Invisible Disability*. Retrieved September 6, 2012, from http://en.wikipedia.org/wiki/Invisible_disability
- Joachim, G., & Acorn, S. (2000). Stigma of visible and invisible chronic conditions. *Journal of Advanced Nursing*, 32, 243-248.
- Mansager, E. (2000). Holism wellness spirituality. *Journal of Individual Psychology*, 56, 237-241.
- Mosak, H., & Maniaci, M. (1999). *Primer of Adlerian psychology: The analytic behavioural cognitive psychology of Alfred Adler*. Philadelphia, PA: Brunner/Mazel.
- National Council on Disability. (2009). Invisible wounds Servicing service members and veterans with PTSD and TBI. Retrieved from <http://www.ncd.gov/publications/2009/March042009/>

- Pachankis, J. E. (2007). The psychological implications of concealing a stigma: A cognitive-affective-behavioral model. *Psychological Bulletin*, 133, 328-345. doi:10.1037/0033-2909.133.2.328
- Post traumatic stress disorder. (n.d.). In *Post Traumatic Stress Disorder*. Retrieved September 6, 2012, from http://en.wikipedia.org/wiki/Posttraumatic_stress_disorder
- Slavik, S., & Carlson, J. (2006). *Readings in the theory of individual psychology*. New York, NY: Routledge.
- Stein, H. T. (1997). *Five fields of striving for significance*. Unpublished manuscript, Department of Psychology, Alfred Adler Institutes of San Francisco and Northwestern Washington. Retrieved from <http://www.adlerian.us/fields.htm>
- Stein, H. T. (1997). *The style of life tree*. Unpublished manuscript, Department of Psychology, Alfred Adler Institutes of San Francisco & Northwestern Washington, Retrieved from <http://www.adlerian.us/tree.htm>
- Sue, D. W., & Sue, D. (2008). *Counseling the culturally diverse Theory and Practice* (5th ed.). Hoboken, New Jersey: Wiley & Sons.
- Swenk, K. L. (n.d.). *Invisible doesn't mean it isn't there*. Retrieved from <http://www.lidaofmichigan.org/articles/Swenk3-06.htm>
- Watts, R. E., & Pietrzak, D. (2000). Adlerian encouragement and the therapeutic process of solution focused brief therapy. *Journal of Counseling and Development*, 78, 442-447.
- What is an invisible disability (2012). Retrieved from <http://www.invisibledisabilities.org/what-is-an-invisible-disability/>