Learning Objectives:

- Understand concept of person centered care
- Identify the most common service delivery model
- Articulate the individual model
- Explain the principles and values of a therapeutic relationship
- Describe the person's role in treatment plan
- Discuss treatment models and how these models impact treatment provision
- Articulate the meaning of rehabilitation
- Discuss the interdisciplinary approach
- Understand the importance of assistive technology for rehabilitation

Models of Disability as Foundations for Rehabilitation:

- **Biomedical Model**
  - Used to understand most health conditions but does not lend itself well to psychiatric or cognitive conditions
  - Uses experts to define characteristics, prognosis, and treatment
  - Two dimensions: normal vs pathological (health vs illness)
  - Deficits are identified, implying there is something wrong with the person with disability; treatment concerned with “getting better”
  - Promotes exclusion of therapeutic services after medical stabilization has occurred
  - Promotes concepts such as treatment plateaus and maximum medical recovery

- **Environmental Model**
  - The environment can cause, define, and exaggerate disability
  - Rehabilitation addresses both physical and social environments
  - Prejudice, discrimination, and stigma are part of the environment and not an inherent part of disability
  - One of the most appropriate models for conceptualizing psychological disabilities
  - This perspective provided for social movements that resulted in:
    - Supported employment and supported living
    - The Americans with Disabilities Act
**Functional Model**
- Most individualized model and serves as the basis for “person centered” care
- Intervention methods are aimed at adapting the function of the individual for meaningful participation (including assistive technology)

**Sociopolitical or Minority Group/Independent Living Model**
- Inclusion, civil rights, and equal social status are the goals
- Highlights society’s responsibility for accommodating people with disability
- Recognizes prejudice and discrimination are causal factors in disability

**Moral or Religious Model**
- Additional model which is not useful as a foundation for rehabilitation
- Views disability as a result of sin, evil, or a character flaw
- People with visible disabilities were devalued immediately
- People with invisible or hidden disabilities like mental illness were isolated and excluded

**Rehabilitation Process vs Progress**
- The term “process” implies a life altering event for which treatment will be needed (Example: severe TBI)
  - Lengthy comprehensive treatment required
  - Impacts family and social network long term
  - Long term negative financial consequences
- The term “progress” implies a known end point. (Example: rehab for a broken arm with goal of full restoration)
  - Focused short term services required
  - Minimal impact on long term relationships
  - Short term financial impact

**Brain Injury Rehabilitation Is A Process.**
The mere acknowledgement of brain injury rehabilitation as a process encourages the individual participating in rehab to own the process and identifies clinicians and family members as tools, supports, and allies in the process.

This is an important and empowering concept for successful brain injury rehabilitation

**Person-Centered Care**
- Empowers individuals to guide the rehab team to focus on their priorities, values, and desired outcomes
- Maintains that:
  - The person served can be trusted to lead their own lives
  - Provider’s attitude and therapeutic relationship are major factors in outcome
  - All people have capacity for self direction and intervention is most effective when requested
Ethical Principles that Guide Therapeutic Relationships

- Integrity: The capacity to act consistently on deeply-held personal values.
- Prudence: The ability to act with discernment and to act in good faith.
- Trustworthiness: The capacity to act and to follow through on promises and commitments, even in the face of difficulty.
- Compassion: Deep concern for another's welfare and empathy for their pain.
- Respectfulness: An attitude that recognizes others' concerns and that commits a person to avoid actions that would diminish another's rights or dignity.

Virtues That Guide Therapeutic Relationships

- Integrity: The capacity to act consistently on deeply-held personal values.
- Prudence: The ability to act with discernment and to act in good faith.
- Trustworthiness: The capacity to act and to follow through on promises and commitments, even in the face of difficulty.
- Compassion: Deep concern for another's welfare and empathy for their pain.
- Respectfulness: An attitude that recognizes others' concerns and that commits a person to avoid actions that would diminish another's rights or dignity.

Critical Components to Facilitating and Maintaining Therapeutic Relationships

- Person Centered Care; the Challenge of Impaired Self-awareness
  - Frontal lobe injury impacts self-awareness.
  - Anosognosia is defined as “inability to recognize deficits or problem circumstances caused by neurological injury.”
  - Self-awareness is defined as “the capacity to perceive the ‘self’ in relatively ‘objective’ terms while maintaining a sense of objectivity.”
  - Impaired self-awareness can exist at all points during the rehab process and can be permanent for some individuals.
  - Importance of treatment - people who improve one level in self-awareness are 30 times more likely to be in the successful treatment outcome group.

Primary Goal of Interdisciplinary Brain Injury Rehab

- To maximize each individual's cognitive, physical, and psychosocial ability while helping the individual to successfully respond emotionally to their specific life challenges.
- The entire team may collaborate on a specific goal.
- Rooted in a functional approach, this is the most common service delivery model for brain injury rehab.

Interdisciplinary Rehabilitation

- Psychiatrists
- Neurologists
- Neuropsychiatrists
- Neuropsychologists
- Behavior Analysts
- Psychologists
- Social Workers
- Case Managers
- Occupational Therapists
- Physical Therapists
- Speech and Language Pathologists
- Respiratory Therapists
- Recreation Therapists
- Nurses
- Substance Misuse Counselors
- Vocational Counselors
- Direct Support Providers
Post Acute Brain Injury Rehab (PABIR)

- For individuals who:
  - Need longer term intensive rehabilitation
  - Manifest hazardous behavior
  - Are unable to manage living independently
  - Lack adequate support while receiving outpatient therapy
  - Without this residential rehabilitation, iatrogenic behavior problems may emerge

Extender Model

- Founded on the idea that maximizing contact with clinically skilled treatment providers will improve treatment outcome
  - Utilization of trained staff as extenders for therapeutic services
  - Extenders are trained in specific therapy skills and supervised by the professional staff member(s)

Assistive Technology for Cognition (ATC)

- One of the most notable advances in the compensation of cognitive issues in recent years
- The integration of ATC is a practice standard for mild memory impairment and a practice guideline for moderate-severe memory impairment
- Mainstream devices (calendar, smart phones, tablets) have great potential and should be part of the toolkit for most brain injury rehab programs

Cultural Competency

Chapter 18

Learning Objectives

- Be able to discuss how culture plays a role in rehabilitation
- Be familiar with the Racial/Cultural Identity Development Model (R/CID)
- Be able to describe the core elements of cultural diversity as a core principle and insist on equality and respect of all groups
- Be able to articulate the concept of cultural diversity as a core principle and insist on equality and respect of all groups
- Be able to describe good ways of creating a climate that is welcoming to those from culturally diverse backgrounds
- Be able to identify the APA guidelines regarding the best approach to working with those of varying ethnic backgrounds

Multiculturalism

- Multiculturalism has been called a social-intellectual movement that promotes cultural diversity as a core principle and insists on equality and respect of all groups
- There is disparity in the use of health care services
  - Only 1 in 3 people who need mental health services accesses them and minorities in particular underutilize these services
- In order to understand how culture impacts the rehabilitation process, we must understand the concepts that form the basis of culture
Ethnicity relates to national origins, which then provides information as to the customs, norms, and languages that are shared across generations.

Race has historically been used to group people based on biological or physical traits, but is now conceptualized by multiculturalists as sociorace.

Sociorace recognizes the social and historical aspects of a group of people, providing information about customs, norms, and social aspects of the group.

Culture is defined as any group that shares a theme or issue. This can include language, food, clothing, music, art, dance, behavioral norms, shared values, and shared worldviews, to name a few.

Race and Sociorace
- Race has historically been used to group people based on biological or physical traits, but is now conceptualized by multiculturalists as sociorace.
- Sociorace recognizes the social and historical aspects of a group of people, providing information about customs, norms, and social aspects of the group.

Racial/Cultural Identity Development
- This model highlights the progression of an individual in establishing his or her cultural experiences.
- The model assumes valuation of the majority cultures (conforming to the majority), and progresses toward valuation of one’s own culture as well as the dominant culture.

Worldview
- The way in which a person approaches their everyday experiences is based on their worldview.
- Worldviews vary and can include cultural, religious, philosophical, and personal perspectives.
- It is important for rehabilitation specialists to consider each individual's cultural and personal worldview and how it has affected them.

Rehabilitation specialists must ask themselves:
- What cultural experiences has each person lived in their lives, and how have these affected them?
There are different constructs of intelligence, each of which speaks to a different ability that can be impacted by culture:

- **Academic (analytical) intelligence** - is used to signify the person's ability to solve problems in academic (classroom) settings.
- **Practical intelligence** - is used to signify the person's ability to solve problems in everyday settings (practical life problems).
- **Social intelligence** - a distinct set of skills necessary in order to successfully navigate the environment.
- **Emotional intelligence** - important in terms of human experiences.

Cross-cultural psychology has documented extensive cultural disparity in human cognition, thought and behavior.

### Creating Culturally Diverse Treatment Settings

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological</td>
<td>Behavior influenced by physiological and genetic makeup.</td>
<td>A patient may have a genetic predisposition to diabetest and depression.</td>
</tr>
<tr>
<td>Cognitive</td>
<td>Thoughts and feelings (i.e., our psychological make-up), can impact our behavior (i.e., our physical behavior).</td>
<td>Stress can impact many bodily systems including musculoskeletal, respiratory, cardiovascular, endocrine, gastrointestinal, and reproductive systems, thus high levels of stress may negatively impact a patient's overall health or impair recovery.</td>
</tr>
<tr>
<td>Social</td>
<td>Social behaviors and relationships can impact our behavior.</td>
<td>A patient experiencing discrimination in a large hospital system may result in deleterious effects on physical and psychological health.</td>
</tr>
<tr>
<td>Cultural</td>
<td>How we behave is impacted by values, practices, and beliefs that are culturally ingrained.</td>
<td>A patient of Chinese descent may respond differently to cultural expectations and norms relative to treatment adherence for their illness.</td>
</tr>
</tbody>
</table>

### Commit to Cultural Awareness

- **Intercultural communication**
  - Emphasis on verbal communication
  - Ambiguous and unstructured therapeutic process
- **Cultural Bound Values**
  - Verbal/emotional/behavioral expressiveness
  - Insight required
  - Self-disclosure (openness and intimacy)
  - Scientific empiricism

### Organizational Change and Policy Development

<table>
<thead>
<tr>
<th>Practice Area</th>
<th>Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commitment to Cultural Awareness and Knowledge of Self and Others</td>
<td>Psychologists are encouraged to recognize that cultural barriers may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves.</td>
</tr>
<tr>
<td>Commitment to Cultural Awareness and Knowledge of Self and Others</td>
<td>Psychologists are encouraged to recognize the importance of multicultural sensitivity/responsiveness to, knowledge of, and understanding about ethnically and racially different individuals.</td>
</tr>
<tr>
<td>Education</td>
<td>Educators are encouraged to employ the constructs of multiculturalism and diversity in psychological education.</td>
</tr>
<tr>
<td>Research</td>
<td>Culturally sensitive psychological research is encouraged to recognize the importance of conducting culture-centered and ethical psychological research among people from ethnically, linguistically, and socially different groups.</td>
</tr>
<tr>
<td>Practice</td>
<td>Psychologists are encouraged to apply culturally appropriate skills in clinical and other applied psychological practices.</td>
</tr>
<tr>
<td>Organizational Change and Policy Development</td>
<td>Psychologists are encouraged to use organizational change processes to support culturally informed organizational/policy development and practices.</td>
</tr>
</tbody>
</table>
**Practical Guidelines and Empowering Language when Providing Care**

- Always practice the golden rule: Treat others as you would like to be treated.
- Always ask before giving assistance.
- Challenge the person to succeed.
- Prompt a response instead of using force.
- Think before speaking and avoid using labels.
- Avoid showing pity or being patronizing.
- Teach individuals living with brain injury to ask themselves proactive questions such as “What is the best way to respond to a situation?”

**Appropriate Auxiliary Aids and Services**

- Importance of interpreters
- Video interpreting services
- Qualified note takers
- Computer-assisted real-time transcription services
- Written materials

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**Aging With A Brain Injury**

**Chapter 8**

**Learning Objectives**

- Understand the concepts of cognitive aging
- Be able to explain the issues of older adults with TBI
- Be able to articulate actions associated with successful aging
- Be able to articulate actions associated with successful aging

**Background**

- Life expectancy has improved for those with brain injury
- Has quality of life kept pace?

- Advances in trauma care have brought about significant declines in death rates due to brain injury
- As these death rates declined, the rates of individuals living with the effects of brain injury have risen substantially

**IOM - Long Term Consequence**

- This long-term outcome information came from studies that looked at individuals with TBI from 1 year to 20 years post-injury
- Disability was related to cognitive, behavior, and personality changes rather than physical changes
- Caregiver burden increased over time and was related to cognitive and behavior issues
- Complications include unemployment, underemployment, lack of residential options, limited social integration, and need for supervision
Long Term Consequences of TBI
Evidence of a Causal Relationship

Population
- Veterans of the Gulf War
- Penetrating TBI
  - Unprovoked seizures
  - Premature death
- Severe or Moderate TBI
  - Unprovoked seizures

Evidence of Causal Relationship

Penetrating TBI
- Decline in neurocognitive function associated with region of the brain affected and volume of tissue lost
- Long term unemployment

Professional boxing
- Dementia pugilistica

Severe or Moderate TBI
- Unprovoked seizures
- Depression, aggressive behaviors, memory problems, insomnia, irritability

Population Evidence of Causal Relationship

Institute of Medicine - Gulf War and Health: Long Term TBI; Volume 7

Long Term Consequences of TBI
Sufficient Evidence of an Association

Penetrating TBI
- Dementia of the Alzheimer's type
- Parkinsonism
- Endocrine dysfunction
- Growth hormone insufficiency
- Adverse social-functional outcomes
- Unemployment
- Diminished social relationships
- Premature death

Severe TBI
- Neuropsychological deficits

Moderate or Severe TBI
- Diabetes Insipidus
- Psychosis
- Increased alcohol and drug use 1-3 years post injury
- Completed suicide

TBI and Dementia

To date, there is no definitive link between brain injury and future risk of Alzheimer's disease (AD)
- Repeated injury was related to a trend for greater risk of AD

Cognitive Aging

Cognitive aging is a general phenomenon that occurs across all people, not just those with brain injury
- Many changes associated with normal aging can be managed with assistive technologies

When Older Adults Experience TBI

- Patterns of cognitive deficits, functional limitations, and measures of recovery will be different from people who are injured early in life
- Falls surpassed motor vehicle accidents as the primary cause of TBI
- Ground level falls in elderly people had greater mortality
- Severity of injury is less predictive

Institute of Medicine - Gulf War and Health: Long Term TBI; Volume 7

Institute of Medicine - Gulf War and Health: Long Term TBI; Volume 7

Institute of Medicine - Gulf War and Health: Long Term TBI; Volume 7

Institute of Medicine - Gulf War and Health: Long Term TBI; Volume 7
Psychosocial Issues in Aging with Brain Injury

- Rates of depression for all severity levels of brain injury are higher than those without, irrespective of preexisting conditions
- The occurrence of brain injury often exacerbates underlying psychiatric issues
- Greater on-going risk for persons with brain injury to experience psychological distress
- Symptoms of anxiety and PTSD are reported in civilians and military

Physical Aspects of Aging with a Brain Injury

TBI is a Chronic Disease process
It is disease causative and disease accelerative

Gender and Sexuality

Chapter 19

Learning Objectives

To gain understanding of unique challenges experienced by LGBT individuals with brain injury in the context of rehabilitation
To explain why sexuality after TBI is often ignored or minimized in brain injury rehabilitation
To identify physical, emotional or behavioral, and cognitive factors that may result in sexual dysfunction following ABI
To identify physical, emotional or behavioral, and cognitive factors that may result in sexual dysfunction following ABI
To share an example of the dating and relationship difficulties experienced by a person with TBI

Differential outcomes by gender

<table>
<thead>
<tr>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>TBI</td>
<td>Outcomes</td>
</tr>
<tr>
<td>Mortality</td>
<td>2.3%</td>
</tr>
<tr>
<td>Poor Outcomes</td>
<td>5.7%</td>
</tr>
<tr>
<td>Cognitive impairment</td>
<td>6.4%</td>
</tr>
</tbody>
</table>
Domestic Violence and TBI
- Battered women report high rates of blows to the head and loss of consciousness
  - Psychological symptoms
    - Distress and worry
    - Anxious arousal
    - Depression
    - PTSD

Psychological Sequela of TBI in Women
- Higher rates of depression compared to men
- Higher rates of PTSD compared to men
- Self-report higher rates of sexual difficulty than men
  - Reported more with mTBI than severe TBI
- Increased symptomology over time
- Complicating factors include a premorbid history of sexual trauma and abuse

Issues Specific to Women after Brain Injury
- Body image concerns that impact self-esteem
- Sexual Dysfunction – problems with positioning, changes in sex drive, inability to achieve orgasm
- Degree of depression and endocrine disorders predict sexual dysfunction in women

Brain Injury and Sexuality Research
- Fatigue
- Brain injury can reduce all drives, including sexual drive
- This is a neurobiological problem, not a reflection of feelings, perceived attractiveness, or value of relationship

Brain Injury and Sexuality Research
- Brain injury can affect diverse neural circuits
- Can impact feelings of pleasure that lead to orgasm
- Medications can impact ability to orgasm
- Causes can be multifactorial

Brain Injury and Sexuality Research
- Pain is common with movement
- Neuro injury can change movement patterns and comfort levels
- Adaptive positioning aids may be helpful

Brain Injury and Sexuality Research
- Over 50% of men and women have associated issues of confidence and esteem, and depression
- This change leads to:
  - Neuromodulatory
  - Reaction to injury disability and change in roles
- Therapy and medication may be of benefit
Brain Injury and Sexuality Research

- Sexual intimacy involves a dynamic exchange between partners
- May not be able to remember the patterns of interaction or may not be able to process those in the moment due to the complex physical and mental energy that is being expended

- Not as common as loss of interest
- Troubling symptom related to frontal lobe injury
- May result in inpatient treatment for safety of the individual and community
- Brain based condition; not character flaw
- Supportive counseling for spouse

- In severe brain injury, neurological control of bowel and bladder (B&B) can be affected
- Learn how to time voiding and manage equipment
- Utilize a caregiver other than sexual partner for B&B to preserve elements of sexual attraction and erotic energy within the relationship
- Brain injury can impact ability to imagine sexual activity
- Further reduces drive and interest
- Counseling recommended

15% continue to have cognitive or psychological difficulties
- Aware of loss of functioning
- “Feel different”
- Men and women may have experienced preinjury sexual trauma or violation
- Can be re-triggered by experience of brain injury

- Neuroendocrine Changes:
  - Changes in the neuroendocrine (hormone-regulated) system occur frequently following brain injury
- Hypothalamus and Pituitary Damage:
  - Pathology studies indicate pituitary damage in 40-62% of persons with TBI and hypothalamic lesions in 42%
  - Changes in neurochemistry and hormone levels affect all aspects of sexual drive, experience, and reproduction (i.e., menstrual irregularities)
- Spasticity
- Hemiparesis
- Ataxia
- Decreased balance
- Movement disorders
- Sensory deficits

Causes of Sexual Dysfunction

Physical Changes Impacting Sexuality:
- Attention and concentration
- Inhibition (motivation to act on a plan or drive)
- Social communication abilities
- Impaired awareness
- Memory loss
- Executive dysfunction

Injury Impacts on Sexual Intimacy

Sexual intimacy involves diverse brain regions

Causes of Sexual Dysfunction

Primary Causes of Sexual Dysfunction

Secondary Causes of Sexual Dysfunction
Causes of Sexual Dysfunction

Emotional and Behavioral Changes Impacting Sexuality:
- Depression (14-61% of persons with brain injury)
- Child-like or dependency behaviors
- Self-centeredness
- Apathy, decreased initiation
- Disinhibition or difficulty with self-monitoring
- Low self-esteem or poor body image

Other Potential Contributors Impacting Sexuality:
- Marital or family dysfunction
- Role changes
- Financial stress
- Parenting strain
- Decreased communication between partners
- Social isolation
- Medication side effects

Why is sexuality not fully addressed in rehab?
- Persons served have difficulty bringing this problem to the team
- Treatment team does not view it as a priority in face of other rehab goals
- Sexual function goals cut across all disciplines

Lesbian, Gay, Bisexual and Transgendered (LGBT) Issues

- 2%-15% of population is homosexual/bisexual
- LGBT individuals with brain injury face unique challenges that are at times mismanaged or ignored in rehabilitation
- Benevolent neglect: staff discomfort and inexperience in treating LGBT patients
- Two factors that contribute to benevolent neglect:
  - Heterosexism: an ideological system that denies, denigrates, and stigmatizes any non-heterosexual form of behavior or lifestyle
  - Homophobia: negative or hostile attitude toward non-heterosexual people

LG BT Issues

- Sexual minorities and sexual subcultures are often superficially addressed in staff cultural awareness or diversity training
- LGBT individuals have many of the same post-TBI sexuality concerns as their heterosexual counterparts
- Family relationships may be faced with unique strains:
  - Differing ideological views
  - An LGBT young adult is injured and his or her family of origin is not aware of their sexual or gender orientation or relationships

SEXUAL INTIMACY

Intimacy can be viewed in four general domains:

Aspects of intimacy that an individual brings into a relationship include:
- Knowledge of self
- Self acceptance
- Awareness of one's strengths and weaknesses
- The ability to experience and share wounding emotions
- Feeling ability to experience and share wounding emotions
- Seeking to choose experiences of this nature
- Any of these can change as a result of brain injury

Sexual Addiction

For persons with few other outlets for successful sexual relationships, the internet can become a consuming world

- Internet-based sexual addiction: growing concern for people with and without disability
- The rapid rise in internet sexual addiction is related to the Triple A of the addiction scenario:
  - Accessibility
  - Affordability
  - Anonymity
Sex Education, Prevention of Sexual Abuse, Exploitation, and Risk

Sexuality has real risks that must be considered and balanced with the right to live a fulfilling life.
- Persons with disabilities, especially cognitive impairments, experience higher rates of sexual abuse of all types, exploitation, rape, and various forms of exploitation.
- Competence for sexual consent must balance protection from harm with promotion of rights.
- Consideration must include:
  - Overall cognitive functioning
  - Safety skills
  - Sexual knowledge
  - Understanding of consequences
  - Overarching ability to make safe and healthy choices.

Adolescent Sexuality and TBI

The primary challenges to healthy sexual functioning after TBI among adolescents are also often due to the secondary causes of dysfunction (damage to the brain).
- Sexuality after TBI is often ignored or minimized in rehabilitation, especially for youth.
- Research demonstrates that non-disabled youth receive much of their sex education (accurate or otherwise) from siblings or friends.
- Youth with TBI do not receive the same level of peer interaction to learn sexual information and cultural guidelines and are far more reliant on parents and professionals to fill this void.
- Accurate, meaningful, and developmentally-appropriate information about relationships and sexuality is critical.

Formal Interventions for Sexuality – Adults and Adolescents

P – for Permission
- What includes advising on the importance of sexuality, how self-esteem and self-concept relate to sexuality, information about changes in sexuality from TBI and through development, and the importance of being able to discuss sexuality openly with family and professionals.

A – for Affirmation
- Receiving acceptance and support for wherever the adolescent is in their sexual development.

S – for Specific Suggestions
- Which typically involve professional interface, such as medical examinations (hormone levels, urology or gynecology, etc.), theater-based interventions that focus on practice habits, interpersonal strategies and social skill issues, and environment modifications, as well as alternative sexual activities or positions.

I – for Intensive Therapy
- Individual, couple or family, to address identified intensive needs.

LI – for Limited Information
- Reviewing the more detailed impact of the TBI on sexual experience, especially key issues such as the challenges that TBI may pose in forming or maintaining a relationship within which an individual may feel secure.

Women and Sexuality

Sexual Difficulties
- Findings from general outcome studies demonstrate that women with TBI experience changes in sexuality and greater relationship difficulties.
- Sexual difficulties documented in a large sample of women included:
  - Problems with arousal
  - Reduced desire
  - Pain during sexual activities
- These difficulties were reported at a higher rate than those reported for non-disabled women.

Relationship and Dating Issues
- Women with disabilities are stereotyped as asexual.
- Lower rates of marriage.
- Reduced opportunities for dating related to:
  - Visible disability deterred dating.
  - Potential partners mistakenly assumed women with certain disabilities were disinterested or incapable of sex.
  - The social pressure against dating a woman with a disability.
- Women with disabilities displayed low self-esteem and self-defeating behaviors.
- Limited mobility or access to transportation impeded dates.
- Cognitive or communication problems made the complexities of dating extremely difficult.