in high-quality paternal care. Examining the other two attributes of the DT, both Machiavellianism and the antisocial subcategory of psychopathy have been linked to lower-quality parental care (Jonason, Lyons, and Bethell 2014). In terms of attachment style, college students who reported limited secure attachment styles were likely to display greater signs of the entitlement/exploitativeness subcategory of subclinical narcissism, Machiavellianism, and the callous attitudes subcategory of psychopathy (Jonason, Lyons, and Bethell 2014). Last, young adults high in Machiavellian traits report low levels of family cohesion and higher levels of chaos, rigid family roles, and poor family communication and functioning (Láng and Birkás 2014). Although research studying the DT in family contexts is limited, the available material illustrates the salient role of this personality profile in close relationships and relational contexts.

Conclusion
Combined subclinical psychopathy, Machiavellianism, and subclinical narcissism compose the personality profile commonly known as the DT. Overall, research has linked the DT with negative interpersonal and family outcomes, and scholars warn against the disadvantageous effects in both the short term and the long term. While scholarship defining, describing, and explaining the DT is plentiful, limited scholarship exists analyzing the function of the DT’s three personality traits in relational settings. Therefore, future research might explore the operations of the DT in various underrepresented contexts, such as incarceration; analyze potentially positive elements of this inherently dark topic; and establish evidence-based recommendations for couples and families to understand and cope with this dark personality profile.

SEE ALSO Communication, Family; Conflict; Relationship Maintenance.

BIBLIOGRAPHY


Physical Disabilities

KELLEY AUCELLO
PsyD Student, College of Psychology
Nova Southeastern University, FL

SARAH VALLEY-GRAY
Professor, College of Psychology
Nova Southeastern University, FL

RALPH E. CASH
Professor, College of Psychology
Nova Southeastern University, FL

An estimated 15 percent of the world’s population lives with some form of disability, with a higher prevalence of disability among older people (World Health Organization [WHO] 2011). Physical disabilities most often affect a person’s ability to perform tasks involving mobility and self-care (e.g., walking, driving, maintaining hygiene, and cooking). Some individuals are born with specific infirmities, referred to as congenital disabilities, whereas others experience physical limitations later in life, referred to as acquired disabilities. Physical disability categories include musculoskeletal and neuromuscular disabilities (Handicaps Welfare Association n.d.) as well as visual and hearing impairments such as blindness and deafness.
Physical Disabilities

Definition and Types

The WHO’s World Report on Disability (2011) describes the concept of disability in the context of a biopsychosocial model. This comprehensive model provides a framework for understanding the nature of disability and its impact on biological, psychological, and social functioning. Disability is defined as “the umbrella term for impairments, activity limitations, and participation restrictions, referring to the negative aspects of the interaction between an individual (with a health condition) and that individual’s contextual factors (environmental and personal factors)” (WHO n.d.). The use of person-first language emphasizes that a disability is a factor in someone’s life but not an attribute of that person. For example, saying “the man who is blind” rather than “the blind man” utilizes person-first language.

Musculoskeletal disabilities are characterized by muscular or bone deformities, including loss or deformity of limbs, osteogenesis imperfecta, and muscular dystrophy. Neuro-muscular disabilities affect an individual’s ability to control movements of affected body parts. Examples of these disabilities are cerebral palsy, spina bifida, poliomyelitis, stroke, head injury, and spinal cord injury (Handicaps Welfare Association n.d.). Musculoskeletal and neuromuscular disabilities fall into the category of ambulatory disabilities and affect individuals’ physical ability to navigate their environment. Implications of these types of disabilities include difficulty traveling, using public transportation, living independently, and coping with negative social stigma.

Blindness and deafness may greatly affect a person’s daily life. According to the Centers for Disease Control and Prevention (CDC n.d.), legal blindness is a leading eligibility criterion for disability benefits and can impair an individual’s ability to drive, read, walk, attain education, and interact socially. The WHO estimates that 360 million people worldwide have disabling hearing loss and that 32 million of these individuals are children. Hearing loss and deafness can be either congenital or acquired. Examples of congenital causes are genetic factors, maternal infection (e.g., rubella or syphilis) during pregnancy, low birth weight, perinatal anoxia, use of certain drugs by the mother during pregnancy, or severe jaundice. Acquired causes include infectious diseases such as meningitis, measles, and mumps; chronic ear infections; fluid in the ears; certain medications; injury to the ear; occupational noise exposure; overexposure to loud recreational sounds; aging; and wax or foreign bodies blocking the ear canal (WHO n.d.).

Socially, people with partial or complete hearing loss may have difficulty communicating while engaging in everyday activities and may experience frustration, loneliness, and isolation (WHO n.d.). Hearing loss may also have an impact on children’s ability to acquire academic skills if they are not provided with the proper educational accommodations.

Disability Theory and Models

Maria Berghs and her colleagues (2016) have discussed theories and models of disability. Four primary models of disability exist, each of which helps guide public health interventions: (1) the medical model, (2) the human rights model, (3) the social model, and (4) the critical disability status model.

Physical disabilities traditionally have been viewed based on a medical model, which focuses on an individual’s impairments or deficits (Pande and Tewari 2011). The human rights model states that those with disabilities deserve to be treated with the fundamental dignity granted to all people. The social model describes an impairment as the disorder or difficulty a person experiences, whereas a disability is viewed as the experience of social isolation, withdrawal, or oppression associated with the impairment. Finally, the critical disability status model focuses on the relationship between impairment and disability, acknowledging that they may exist together.

Thomas Hugaas Molden and Jan Tøssebro (2011) stated that in the past, society viewed disability according to the medical model, evidenced by health measures, policies, and actions that neglected other salient effects of disability on individuals’ daily living activities and quality of life. Examples of these issues as defined by the medical model include mobility and assistance with daily activities as needed (e.g., hygiene, eating, toileting, self-care). Strides are being made in disability advocacy, focusing on viewing individuals with disabilities through the human rights model such that they are seen as more than just their disabilities or as simply having health care problems that need to be fixed.
Prevalence and Schooling

According to the US Census Bureau (2011), approximately 2.8 million children (5.2%) in the United States were reported to have a disability in 2010. The most common disability (4–5%) was cognitive difficulty (serious impairment in concentration, memory, or decision-making ability), and problems with hearing, vision, ambulation, and self-care made up the remaining areas of disability. Overall, 86.2 percent of children with no reported disability were enrolled in public school in 2010, while 11 percent were enrolled in private school, and 2.8 percent were homeschooled. In contrast, 89.4 percent of students with disabilities were enrolled in public school, while 7.3 percent were enrolled in private school, and 3.3 percent were homeschooled.

When considering children with disabilities enrolled in school by disability type, however, the percentage of those who were homeschooled increases. Specifically, 4.3 percent of children with vision difficulties, 5.2 percent with self-care difficulties, and 6.7 percent with ambulatory difficulties were homeschooled. This is double the percentage of children who were homeschooled when compared with nondisabled children (US Census Bureau 2011). This disparity may have been due to problems specific to the public education system, such as limitations in services provided for students, parental difficulty with the public school special education process, or frustration with the educational placements offered. Alternatively, parents may have felt that their children would benefit more from being educated at home, where they could receive personalized attention and would not feel stigmatized by nondisabled peers. There are many reasons why parents may choose to send their children with disabilities to formal schools or alternatively to educate them at home, and each family may have different reasons and circumstances.

Social Emotional Well-Being

People with physical disabilities are at a higher risk of emotional distress than those in any other disability category (Bramston and Mioche 2001). This distress may be influenced by factors such as age, sex, education, and socioeconomic status. Physical disabilities often have impacts on major daily living functions, such as traveling to work, climbing stairs, and driving, making it difficult for individuals with these disabilities to navigate the world. Additionally, negative perceptions of individuals with physical disabilities may lessen social support and add to emotional stress.

Coping Strategies and Resilience

In the context of physical disabilities, the construct of resilience has been extensively studied in determining whether children have adequate coping strategies to interact with their environments despite their physical disabilities. Children with disabilities with high levels of resilience may have better life outcomes than those who do not have such resilience, because they have cultivated strategies, coping mechanisms, and a positive life outlook to help them through adverse life situations.

According to Byron Egeland and his associates (1993), resilience can be understood as individuals’ ability to master stressful situations in an effective, developmentally appropriate way through interactions with their environment. Resilience is developed as the child faces and surmounts more challenges posed in the environment. Ann Masten (2001) and Michael Rutter (1987) agreed that children find resilience through facing serious obstacles in their lives and acquiring adaptive coping strategies for use in the future. These adaptations are based on the child’s developmental level and may change over time as the significant threats change and as the child matures. These adaptations are affected by preexisting risk and the protective characteristics of the specific child. As children successfully adapt to more serious life threats, their resilience grows, thereby improving adaptability and self-esteem.
Risk factors are variables in individuals' lives that make it more likely for them to experience negative outcomes. Risk factors affecting the development of resilience can be found within the individual, the family, and society. They may include variables such as family problems, lower levels of parental engagement, a failure to validate the child, harsh and inconsistent discipline, and a family history of mental illness (Armstrong, Birnie-Lefcovitch, and Ungar 2005).

By contrast, protective factors foster an individual's ability to attain positive life outcomes by mediating the relationship between stress and competence (Armstrong, Birnie-Lefcovitch, and Ungar 2005). Rutter (1987) added that there are mediating mechanisms related to the development of protective factors among youth with disabilities. They include (1) limiting the impact of exposure to stress or traumatic events, (2) developing positive self-esteem, (3) reducing sensitivity to risk, (4) compensating for risk with positive experiences, and (5) processing negative events in a positive way through cognitive strategies. Overall, manageable stressors and life events may serve as ways to build resilience while improving positive self-esteem through successful adaptation to the environment.

For children with disabilities, protective factors that help to increase resilience include strong problem-solving skills; the ability to elicit positive, healthy attention from others; the tendency and ability to seek out new experiences; and an overall positive, optimistic outlook on life, despite facing adversity (Armstrong, Birnie-Lefcovitch, and Ungar). Protective factors also exist at the family level and may include the parental age of the opposite-sex parent (i.e., younger mothers for male child resilience and older fathers for female child resilience); consistent caregiving during the first year of life; nonparental caretakers who provide support when the parents are unavailable; a network of relatives of different ages; sibling caretakers; and healthy discipline, structure, and rules during adolescence (Rak and Patterson 1996). These protective factors all encompass positive social support for the entire family and consistent caregiving for the child.

**Bullying.** Children with physical disabilities are at increased risk of being bullied (Dawkins 1996). Educators should be aware of this vulnerability to being bullied among children with physical disabilities as they plan interventions and services.

To intervene early, it is important to be vigilant for signs of bullying, low self-esteem, anxiety, depression, and other mental health concerns among children with disabilities. Schools should implement preventive action to emphasize
Physical Disabilities

the beauty of diversity, treatment of others with respect, and education of all students regarding disabilities. For example, school-wide evidence-based interventions such as Caring School Community can create a positive school climate that aids students in understanding one another, including students with disabilities (What Works Clearinghouse n.d.).

Rehabilitation Psychology. Rehabilitation psychology is based on “social inclusion, participation, empowerment, and advocacy,” which are useful in addressing individuals with disabilities as well as advocating for societal changes (MacLachlan and Mannan 2014, 120). This area of psychology was created during World War II to attend to the needs of soldiers who survived serious injuries. Rehabilitation psychology focuses on aiding individuals with disabilities using the “ABCs” of rehabilitation psychology: adjustment, behavioral interventions, cognitive remediation, compensatory skill building, and consultation. Malcolm MacLachlan and Hasheem Mannan (2014) addressed how rehabilitation psychologists can aid in challenges that are described in WHO’s World Report on Disability (2011).

The authors stated that rehabilitation psychologists can have a positive impact on the lives of individuals with disabilities and that efforts should be made to expand this area of practice, particularly to low-income countries, where psychological services are less prevalent.

Family Relationships. Family relationships for children with disabilities may be complex and stressful. According to Ian Dempsey and Deb Keen (2008), family-systems theory is centered on the concept that children’s families constitute the core support in their lives. A supportive family that provides for a child’s needs and well-being is a key contributor to a child’s positive outcome. It is important for families to be involved in decision-making on the child’s behalf. Those working with families should respect the family’s strengths and emphasize a collaborative relationship between the family and health practitioners.

Social support is a protective factor that can reduce stress in families that have a child with a disability. Families that have support can rely on and trust other people (e.g., other family members, friends, and neighbors) to help them, which may lessen financial, emotional, and interpersonal stress. Families with social support perceive less stress than families who do not have the same level of social support. Additionally, parental empowerment, parenting competence, a child’s behavior problems, and a child’s level of disability may all contribute to the family-system dynamic and affect perceived stress (Keen et al. 2010).

Social support comprises two components: the main effect and the buffering effect. The main effect of social support is beneficial to everyone, whether or not the individual is experiencing stress. The buffering effect of social support eases the harmful effects of stress to which an individual is exposed (Armstrong, Birnie-Lefcovitch, and Ungar). Parents of children with disabilities have smaller social support networks with fewer friends but more connections between each of the parents’ networks compared with families without children with disabilities (Kazak and Wilcox 1984). The effects of both components are important for all individuals, no matter their level of stress.

Treatment of Physical Disabilities

Many individuals with physical disabilities require therapies or treatments to improve their quality of life, including occupational therapy, physiotherapy, speech therapy, and medication or vaccination. Some individuals with physical disabilities have additional struggles in coping with their disability because of a comorbid psychiatric disorder. Comorbid disorders are disorders that often occur together, such as anxiety and depression. Psychotherapy may serve as an additional therapeutic intervention to help individuals with disabilities cope with life stressors.

Conclusion

Approximately 15 percent of the world’s population has some type of disability, creating a need for information, health care policy advocacy, and research to improve their quality of life. Physical disabilities include musculoskeletal and neuromuscular disabilities, visual impairments, and hearing impairments. Each of these disabilities may affect an individual’s life satisfaction and daily functioning in tasks such as walking, traveling, independent living skills, reading, and attending work and school.

Nearly twice as many children with disabilities are homeschooled compared with the number of nondisabled students who are not enrolled in school. The highest rate of nonenrollment in schools is found among children with ambulatory disabilities, followed by children with visual impairments or blindness. Many children with disabilities are also victimized in school and may be bullied by their peers owing to physical differences and disabilities.

Children with disabilities benefit from attaining and strengthening coping strategies and from efforts to increase resilience. Coping skills are acquired and enhanced when children successfully face stressful life events and effectively handle them in a developmentally appropriate manner. Risk and protective factors in a child’s life will have an impact on the development of healthy coping strategies and resilience. Positive family relationships and social support are important for improving the lives of children with disabilities and their family members. Families with strong social supports report less stress and better outcomes than families with limited social support.

The latest information on factors relating to physical disability status has placed disability toward the forefront of public policy change, educational research, and prevention.
Considering the research and data can help the general population of students become better informed, reduce the stigma associated with disability, and integrate into society those who have previously felt isolated. With 15 percent of the world’s population affected by a disability, it is important to recognize our similarities rather than our differences and to unite with one another.

SEE ALSO Bullying; Family Systems Theory; Homeschooling; Learning Disorders; Parent-School Involvement; Pediatric Conditions; Resilience.

BIBLIOGRAPHY


Pillow Talk

AMANDA DENES

Associate Professor, Department of Communication
University of Connecticut, Storrs

MARGARET BENNETT

Doctoral Student, Department of Communication
University of Connecticut, Storrs

Pillow talk is defined as “the communication between two individuals after they engage in some form of sexual activity with one another” (Denes 2012, 92). Pillow talk occurs during the time interval after sexual activity, also referred to as the postcoital or post-sex time interval, which is defined by Daniel J. Kruger and Susan M. Hughes as the time immediately after sexual activity “before one partner leaves or falls asleep” (2010, 255). The majority of research on post-sex communication has focused on favorable aspects of pillow talk and positive relational disclosures after sexual activity, which Amanda Denes defines as the communication of “positive aspects of the relationship between the two partners such as declarations of love, affection, and intimacy” (2012, 95). Research on pillow talk has built upon the