THERAPEUTIC INTERVENTION FOR THE PHYSICALLY HANDICAPPED

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Abstract

The need for training counsellors specifically for intervention with the physically handicapped is the major focus of this article. Definitions of disabilities, rehabilitation and emotional factors are stressed as important variables in physical and psychotherapeutic treatment. The authors review some of the psychological aspects in counselling the physically handicapped. Comparative studies are reviewed which indicate that although there are many commonalities in counselling physically able and disabled clients, special attention is given to those factors in the counselling process that are unique to a physically handicapped client-counsellor relationship.

Résumé

Cet article vise à souligner le besoin de former des conseillers prêts à travailler avec des personnes handicapées. La définition des infirmités, la réhabilitation et les facteurs émotionnels représentent des variables importantes dans le traitement tant physique que psychothérapeutique. Les auteurs passent en revue certains des aspects psychologiques dans la consultation auprès de gens handicapés. Des études comparatives indiquent un fond commun dans la consultation auprès de personnes handicapées et normales. Cependant, on accorde une attention spéciale dans la consultation aux facteurs qui sont uniques au rapport conseiller-personne handicapée.

From a recent review of university calendars it would appear that most Canadian University Departments of Psychology and Educational Psychology do not provide graduate training programs dealing specifically with the physically handicapped. This leaves one to assume any training in this area is largely coincidental and subsumed under regular counsellor training programs in a haphazard fashion. While it may not be surprising, it is unfortunate when one considers there were an estimated 9 million visually and auditorily handicapped out of 83.3 million youth from birth to 21 years of age in the United States in 1970 (Kakalik, Brewer, Dougharty, Fleischauer, Ginensky, & Wallen, 1974).

A Brief History

The essence of the problem takes on larger proportions when the long history of rehabilitation is considered. It began with the use of splints during the Egyptian Dynasty of 2700 to 2500 B.C. (Alexander & Selesnick, 1966; Roback, 1961), evidence of artificial limbs, massage and exercise for dislocated limbs, and financial support for the disabled during the 500 to 300 B.C. period (Alexander & Selesnick, 1966; Arieti, 1959; Sigerist, 1964).

The modern era of rehabilitation in North America can be thought of as taking place during two periods, the 25 years before World War II and the subsequent years. In 1919 laws were established in the United States giving the disabled rights to the services which would establish them as productive persons in society. This brought about the establishment of clinics with facilities for physical therapy, vocational rehabilitation, and educational training. However, it was narrow in scope and focused almost exclusively on medical problems. The principle targets were those crippled by loss of limbs or with locomotive impairment. While medical expertize was developing, poor social and vocational adjustment was hampering rehabilitation. Thus, the second period started with a growing emphasis on vocational training. But this too, was destined to expose further problems. There were the social and emotional difficulties of the handicapped, and social attitudes, such as employer resistance to hiring the disabled (Neff, 1971). It would seem the concept of rehabilitation was indeed more complex than first thought.

Defining the Disabilities

Taking a social psychological viewpoint Kutner

1. In Canada, the estimate for visually and auditorily handicapped is believed to be around one million individuals (Canadian Paraplegic Association, 1977).

(1971) defined a disability as:

> an enduring measurable or testable impairment of function emanating from psychological disorder, physical illness, injury, or congenital malformation and producing long-term (though not necessarily irremediable) changes in the performance of normally expected social roles and behavior. (p. 144)

In summarizing the principles which emerged from the 1958 Princton Institute on rehabilitation Vineberg (1971) stated:

> Rehabilitation stresses the human worth, assets, and social potentials of all persons, no matter how severely disabled; it requires that treatment plans be indivisualized and conducted with participation of the patient and involve agencies of the community, as well as a variety of helping professional disciplines; . . . and it recognizes that psychological factors are crucial in all aspects and stages of the individual's adjustment to social life and in the acceptance and support that he receives from others. (p. 311)

A modern definition of rehabilitation states it is "the process of assisting the individual with a handicap to realize his potentialities and goals, physically, mentally, emotionally, socially, and economically" (Seidenfeld, 1959). This recognizes that factors such as family relationships, personality traits, emotional stability, and the attainment of independence may be as important as physical rehabilitation.

The disabilities of concern to this paper are not those which could be considered to have a psychosomatic component, such as duodenal ulcers, ulcerative colitis, or obesity. Rather, that wide range of physical impairments which effect the function of muscles, bones, joints, senses, and neuromuscular activity, such as cerebral palsy, communicative disorders, loss of sight or hearing, and loss of limb, is under discussion.

The most common form of cerebral palsy seen in children is the spastic type. Because opposing muscles operate antagonistically instead of working in conjunction, the child may be characterized by poor enunciation, use of words and sentences, and slow, stiff movements. Various sub-groups include those where arms and legs are involved (*quadriplegia*), legs only (*paraplegia*), one side of the body (hemiplegia), and muscles of the tongue (spastic tongue).

Athetosis is another common type of cerebral palsy. Rather than the slow and labored movement of the spastic, athetoids are constantly in motion. Unable to control movement they may turn their head from side to side, legs may roll in and out when trying to walk, or hands may move involuntarily from palm up to palm down positions. Backward and forward motions, limbs remaining twisted for periods of time, and limbs being floppy or stiff are among other characteristics.

Emotional disturbances of the cerebral palsied are a universal complication. The mildly disabled seem to show greater disturbance of their emotional life than the more seriously disabled. Those who come from overprotected environments display evidence of lower motivation (Grossman, 1953). Generally, the psychological needs of the cerebral palsied are the same as those of the non-handicapped. They want emotional acceptance and a sense of personal worth.

Speech and language disturbances include articulation disorders, cleft lip, cleft palate, and aphasia. Of these, articulation disorders are the most common, and in severe cases may render communication impossible. Abnormality of pitch, intensity, and timbre are used to classify disorders of the voice. Aphasia is the result of a cortical lesion which is manifest in the inability to use or understand speech.

Severe visual and auditory handicaps are readily apparent and are quickly recognized and dealt with. However mild functional difficulties are often not recognized and deficiencies in adjustment may be erroneously blamed on other factors. While both groups have some common problems in self-acceptance and understanding their social milieu, their basic problems are different and require separate rehabilitation procedures (Meyer, 1953).

Psychological Factors to Consider in Counselling

While the counselling psychologist must have some knowledge of the psysiological and medical aspects of physical disabilities it is the psychological characteristics which are his chief concern. As Kellmer Pringle (1964) pointed out, the disabled are not inevitably disturbed, but most comparative studies indicate the handicapped are less mature than the non-disabled. Others state there is no evidence for higher rates of emotional disorders among the handicapped (Graham & Rutter, 1970). However, there are indications the physically disabled have more problems with social relationships (Centers & Centers, 1963a; Kinn, 1964; Richardson, Hastorf, & Dornbush, 1964; Sherwin & McCully, 1961) and greater feelings of anxiety, conflict, and defensiveness (Centers & Centers, 1963b; Wysoki & Whitney, 1965).

When a person is rendered disabled, mental and emotional confusion result (Fordyce, 1971). Adjustment is complicated by the ability of humans to affect their own emotions by their verbalizations of what the present is and what the future will hold (Michael, 1970). Further, dependency appears to be a major problem in almost every aspect of rehabilitation. While some acceptance of the dependent role seems to be a

positive factor in successful rehabilitation, some use their disability as a "means of extracting the last ounce of attention and energy from their caretakers as a means of avoiding personal responsibility, and as a weapon to demand love" (Kutner, 1971, p. 161).

Diller (1959) considered body image and its effect on the adjustment of the disabled by psychological rather than a physiological factor. Pain, for example, is usually considered a physiological phenomenon. However, it can be regarded as an affect warning the ego of a threat to body loss or excess body stimulation. The psychology of bodily feeling appear to be important in such areas as schizophrenia and phantom limbs. Szasz (1957) viewed the phantom limb phenomenon as extremely important to rehabilitation, paralleling it with paranoia, projection and denial.

Because the physically disabled does not have a body comparable to most others he is devalued by himself and society (Diller, 1959). Pilling (1972) indicated that the unfavorable view of others may be a more important factor than the actual disability. Studying amputee children, Centers and Centers (1963a) found them to be more refected than their normal classmates, and Conine (1969) stated teachers' attitudes may be a critical factor. Prejudices toward the disabled stem from general aversiveness toward difference and weakness (Kutner, 1971). The negative attitudes are multidimensional in nature (Farina, Sherman, & Allen, 1968; Kleck, Oni, & Hastorf, 1966), and affect the handicapped person's self-esteem (Eisenman, 1970). Acceptance of an impaired body requires a difficult change in values. Denial of one's physical impairment leads to greater maladjustment. To further complicate matters, society usually implies mental inferiority with physical disabilities (Barker, Wright, Meyerson, & Gonick, 1953; Cath, Glud & Blane, 1957).

Manson and Devins (1953) found the best criterion for prediction of successful rehabilitation to be the individual's pattern of resolving frustrations, attitudes, and problems of daily living. In general those who were insecure, immature, neurotic, and psychopathic have the most difficulty. While these were predictable other factors were uncovered. For example, married men had a better attitude than unmarried, separated, or divorced men. In addition the better educated recovered faster, experienced less pain, and did not show evidence of experiencing phantom limbs.

Several factors should be considered in the therapeutic setting when the disabled is subjected to environments which regulate his life, develop plans for him, and evaluate him in terms of how well he cooperates with others. The situation will be ambivalent, the setting, goals, and procedures will be unknown, and initial behavior will be inefficient, resulting in frustration and conflicts (Shontz, 1967).

The principles of communication during counselling, regardless of the situation, have a common denominator. In all cases one must provide a situation and an experience which is psychologically constructive. For illustrative purposes the following points have been stated by Kagan (1967). The physical setting should be consistent with the psychological purposes of the interview. The physical setting should be structured suitably to counselling the disabled. The counsellor must recognize and accept the fact of individual differences on the level of the handicapped. In the case of the disabled, self-determination and self-enhancement should especially be fostered, and adequate knowledge of placement in vocational areas must be demonstrated.

Rehabilitation Techniques

Sources of rehabilitation techniques for cerebral palsied pre-school children can be found in Brereton and Sattler (1967), as well as specific suggestions for parents and teachers in Henderson (1961) and Phelps, Hopkins, and Cousins (1958). These references outline in detail basic visual-motor and perceptual ability tasks necessary for rehabilitation and for full intellectual functioning. Psychological aspects of children with cerebral palsy and implications for treatment are covered in a report by Miller and Rosenfeld (1952). A medical guide for teachers to physical disabilities is available in Bleck and Nagel (1975). Cobb (1973) presented an explanation of disabilities along with their psychological, social, and vocational factors, and a survey of pertinent theories and research approaches is available in McDaniel (1969).

Modern technical developments have assisted in enabling the physically limited to have greater independence and freedom. Equipment has been developed to allow almost totally paralized people to operate wheel chairs and typewriters (Collins, 1967; Jessop, 1967; Selwyn, 1967). Factories have been established where many types of severely disabled can partake in light assembly work, drilling, tapping and reaming, and packing (Morley & Smith, 1967). The advent of easily accessable modern computors enables the handicapped to participate in specially designed computor assisted instruction program ("Cerebral Palsy Association", 1977).

In conclusion, the traditional role of the psychologist in the rehabilitation of the physically disabled has been one of a consultant with limited interaction between himself and the client. This has not been particularly effective and Fordyce (1971) proposed that psychologists take respon-

sibility for the direct application of behavioral principles in the rehabilitation process. As Brieland (1971) point out, the comments of Allan (1958) are still pertinent.

> Psychological counseling has been a much discussed, but loosely defined phase of activity in rehabilitation. To a degree, all the professional and lay persons participating in rehabilitation programs are concerned with certain principles of individual psychology. The entire reaction of a person to his mental or physical handicaps, and the whole process of rehabilitation as related to that handicap, are based upon psychological adjustment. In a formal sense, however, there has not been as much use of the trained psychologist in rehabilitation as one might reasonably expect. (p. 69)

Considering the long history of physical disabilities rehabilitation, that era one might consider the modern period has been quite brief. The past 60 years have seen many advances, particularly in the medical and technical areas. As we have seen, much has been gained in the psychological realm as well, but much more needs to be done. If psychologists in Canada are to be prepared for working with the handicapped and are to assume new roles and responsibilities, there must be counsellor training programs and research designed specifically for working with the physically disabled.

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