

## ON COUNSELLING THE PHYSICALLY DISABLED\*

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### Abstract

It has long been recognized that people who become physically disabled typically experience certain sequential stages (denial, hostility, depression) before achieving a measure of psychological adjustment to the disability. These stages are discussed in terms of their dynamics and the counselling goals and strategies appropriate to each. To help a client overcome the handicapping effects of physical disability, a counsellor should have a rudimentary knowledge of the behavioural manifestations of the medical condition, and be skillful at implementing counselling strategies which are compatible with the intra and interpersonal dynamics characteristic of each stage.

### Résumé

On reconnaît depuis nombre d'années que les personnes devenues handicapées physiquement traversent certaines étapes séquentielles (le refus, l'hostilité, la dépression) avant d'acquérir une adaptation psychologique à leur infirmité. On discute ces étapes selon leur dynamique et les buts et stratégies qui conviennent à chacune. Afin d'amener le client à surmonter les effets limitatifs de son infirmité, un conseiller doit posséder une connaissance élémentaire des manifestations extérieures de la condition médicale et être apte à utiliser des stratégies de consultation compatibles avec les dynamiques intra et interpersonnelles propres à chaque étape.

### INTRODUCTION

During the last twenty years, literature in Rehabilitation Psychology has increasingly documented the fact that handicaps as such are imposed by society (Dembo, Leviton, & Wright, 1956; Kutner, 1971; McDaniel, 1976; Neff & Weiss, 1965; Pulton, 1976; Wright, 1960). In this regard it is important not to confuse "handicap" with "disability", a distinction which will be discussed later in this paper.

Much needs to be done on municipal, provincial and national levels to decrease the handicapping effects of Canadian society. Some of the needed changes are obvious: e.g., changing building codes so that public buildings are truly accessible to all of the public. To get some idea of the architectural barriers involved, the writer recommends, that you borrow a wheelchair for a day and try to get around your city. Could you get into your own home in a wheelchair? Could you get into the bedroom? The bathroom? Could you manoeuvre around the kitchen?

Perhaps that gives you a flavour of some of the architectural barriers faced by people with restricted mobility. Other necessary changes include developing transportation which disabled

people can use and providing human rights legislation to decrease the discrimination that is sometimes directed at people with physical disabilities.

This paper attempts to integrate the writer's experience as a person in a wheelchair with the literature on psychological aspects of physical disability. Specific suggestions as to what individual counsellors can do to help the disabled become more accepting of themselves and others, and thereby live more productive, fulfilling lives will then be given. It is the writer's belief that much of the responsibility for societal acceptance rests with the disabled themselves. Consequently, the major goal of counselling must be seen as helping the person with a disability acquire the skills necessary to carry out this responsibility. The writer shall mention the psychological stages associated with physical disability, and what counsellors can do to help people through these stages.

### DISABILITY VERSUS HANDICAP

First of all, it is important to distinguish between "disability" and "handicap". These terms are often used interchangeably, but the writer believes it is helpful to consider them as different. Hamilton (1950) was probably the first to distinguish "disability" from "handicap". He defined "disability" as a medically diagnosable

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condition in which the body, or some part of it, is not functioning as it should. Thus, blindness, cancer, tuberculosis, and ulcers, are disabilities. "Handicap", on the other hand, refers to an interaction between the individual and the society in which he lives. The writer is handicapped in that he is confined to a wheelchair in a society that has many stairs. The importance of this distinction is that "disabilities" may be "handicaps" but are not necessarily so. People who wear glasses or contact lenses have a disability in that they do not have 20:20 vision, but in our society they are not handicapped. Similarly, left-handed people sometimes find themselves handicapped by a world built for the right-handed but left-handedness is not a physical disability.

The point is that a person may be "disabled" without being "handicapped" or may be "handicapped" without being "disabled". With these introductory remarks then, the writer would like to turn to what happens to a person who becomes physically disabled.

#### STAGES AND THEIR UNDERLYING DYNAMICS

The field of rehabilitation widely recognizes the fact that people who become disabled go through three discrete, but often overlapping, stages of psychological reaction (McDaniel, 1976; Vargo, 1978; Wright, 1960). Because the loss of previous function may be perceived to be akin to loss of life, these stages are analogous to those experienced by people who are terminally ill (Kubler-Ross, 1970). Kubler-Ross (1970) identifies five such stages but the writer condenses these into three as proposed by Wright (1960).

##### 1. Denial

The first stage is denial. In the denial stage, the person refuses to admit the presence of the problem. This is denial in the Freudian sense, that is, the unconscious blocking of reality. When the writer broke his neck at the age of twelve and was told by physicians that he would never walk again, he responded "of course I will". For months he denied the fact of his condition even though he could not move from the neck down. It would have been too devastating for him, at that time, to admit that he would be unable to walk.

Denial seems to serve a valuable psychological function in that it protects the ego (self) from overwhelming threat. The value of denial as a reaction to disability has been extensively discussed (e.g., Dembo *et al.*, 1956; McDaniel, 1976; Simon, 1971; Wright, 1960). However, at some point, perhaps days, weeks, or even months after the onset of disability, the person moves out of the denial stage into the stage of mourning.

##### 2. Mourning

The stage of mourning seems to have two phases: hostility and depression. In psychodynamic terms, hostility is anger directed outwards onto the world and depression is anger directed inwards onto the self. Whether the analytic interpretation is correct is not important. What is important is that these two behaviours manifest themselves in almost everyone who suffers a disability.

First of all, the anger is directed outwards onto the world. Hospital staff know of many instances where patients have asked a member of the nursing staff to get something for them and the staff member has responded: "I'm going down that way in a few minutes." or "Can you wait a minute?" The hostile patient might say "Don't be so lazy! You should be damned thankful that you can walk and get it!" People in this phase are very trying to work with because our first reaction when someone lashes out at us is to lash back. Usually after the hostility phase the person becomes depressed, withdrawn, and non-communicative. The hospital rehabilitation team will say "Mr. Smith isn't cooperative. He is not doing what the doctor recommends."

Stage Two generally lasts anywhere from 6 to 12 months (Simon, 1971). To the writer's knowledge, there is only one report in the literature where somebody who became severely disabled did not experience this stage (Goldiamond, 1973). Israel Goldiamond (1973) was well known in the behaviour modification field when he became a paraplegic as a result of a car accident. In an account of his hospital experience reported in *Psychology Today*, he claims to have experienced neither hostility nor depression. But Goldiamond was treated somewhat differently than most hospital patients. In true behaviour modification fashion, he recorded everything pertaining to the rehabilitation process: how many hours he slept each night, when he woke up, what kind and how much medication he was taking, what was happening with his movement, the progress he was making in physiotherapy. Everything was recorded, including his emotional states. Furthermore, he made special arrangements through the university to conduct his classes from the hospital bed. Consequently, his lifestyle wasn't changed as dramatically as for example, that of a labourer, who at the age of 43 becomes a paraplegic and says "What can I do? I worked in construction all my life. What am I going to do now?" Some of the dynamics of the stage of mourning are especially important. Wright (1960) mentions ten misconceptions that people with disabilities have about their disability:

1. My disability is a punishment.
2. It is important to conform, not to be different.
3. Most people are physically normal.

4. Normal physique is one of the most important values.
5. Physique is important for personal evaluation.
6. A deformed body leads to a deformed mind.
7. No one will marry me.
8. I will be a burden on my family.
9. My deformity is revolting.
10. I am less valuable because I cannot get around (or see, or hear) as others do. (p. 172)

These misconceptions are the focal point of many of the problems that people with physical disabilities experience. One of the things that counsellors can do is systematically de-propagandize those misconceptions in the manner advocated by the cognitive behaviour therapists (Ellis, 1962, 1965; Raimy, 1975).

The depression phase of the stage of mourning is not much different from the kinds of depression you see in people who aren't disabled. People who are depressed because of their disabilities exhibit the traditional, clinical symptoms of depression. Seligman (1975) calls depression the "common cold of psychopathology" (p. 76). He says: "Depressed people believe themselves to be even more ineffective than they actually are: small obstacles to success are seen as impassible barriers, difficulty in dealing with a problem is seen as complete failure, and even outright success is often misconstrued as failure" (p. 85). In other words, depression is viewed as perceived helplessness: The sense of having no control over one's environment is the essence of Stage Two.

### 3. *Adjustment*

Wright (1960) refers to Stage Three as "Adjustment". In this stage the person gradually begins to emerge out of the hostility and depression and takes psychological stock of oneself: abilities, strengths and weaknesses. Once people begin working through the adjustment stage (which lasts for the rest of their lives as it does with all of us), they direct more energy toward what they can do rather than what they cannot do.

Those are the stages that people typically travel after experiencing some form of physical disability. What is important now is what counsellors as individuals might do to help clients reach Stage Three.

## IMPLICATIONS FOR COUNSELLING

The counselling strategy to use depends on the stage that the client is experiencing. If the client is in the denial stage, of course the goal is to move the person out of denial. Probably you will not see clients in this stage unless you work in an active treatment hospital. If you do, though, the goal is to gently push them into Stage Two, which means getting them to become hostile or depressed. It goes against the grain of counsellors to make a person depressed or hostile, but in this case it is a

necessary therapeutic step. The writer stresses "gently push" because, since denial is protective, you don't want to force the issue. If the client says "Well, I'm soon going to be better anyway." (you might see people like this who don't go to therapy and don't take medications because the disability is "only temporary"), you might say something like "Okay, you might recover soon, but you're not better now, so let's see if we can make your time easier for the present." Sometimes that helps in bringing the client closer to the realization that perhaps the problem is not "only temporary".

Most clients you see will be in the mourning stage. If they are experiencing hostility, your goal is to gain their trust and rapport just as you do with any kind of client. That may be difficult if you are dealing with somebody who has a disability that you don't have. An amputee, for example, might say "How do you know what it's like to have both legs amputated? It's easy for you to say, you can walk."

One strategy you may use in gaining rapport and trust is to create cognitive dissonance in the client by communicating unconditional positive regard. For example, if the client is hostile and lashing out, you may defuse the hostility by creating an atmosphere which allows for the expression of all emotions without the fear of reprisal or rejection. Unconditional acceptance might cause the client to think: "Maybe the counsellor likes me for what I am. Maybe he likes me as an individual. Maybe physique isn't so important." Hospital patients typically develop school-child crushes on their therapists. Perhaps it's because for the first time since the onset of the disability, the client discovers that someone likes him just because he is him.

Another strategy is to provide descriptive feedback to the client. Feedback described in behavioural (rather than evaluative) terms can modify self-concept. For instance, most people have difficulty describing their strengths. An important role of the counsellor is to identify strengths to their clients that the clients may not see in themselves. This means observing them closely and providing objective, descriptive feedback on the parts of their lives that they are managing effectively. Build the base for a solid, problem-solving approach to life.

If the client is depressed, the approach to use is the same as for almost any kind of depression. The goal is to instill self-respect, a feeling which people who are feeling depressed do not have. Seligman (1975) views depression as "learned helplessness", i.e., people feel depressed when they have no control over their environment. They feel helpless. Depressed people seem to think it's important to dwell on what's depressing them which tends to make them more depressed which tends to make

them worry more, locking them into a vicious circle.

One strategy is to de-propagandize the misconceptions that underlie the depression and help the client achieve a sense of control. De-propagandizing the misconception associated with disability means overcoming what the writer calls the "ideology of normality" (Vargo, 1978). It is a disservice to tell people with physical disabilities that "you're no different". Of course they are different. But physical difference need not be the most important concern in life. The important fact is that *people can be different and equal*. De-emphasizing or overcoming the ideology of normality means focusing on competence, on what people *can* do. What goals do they have in life? How might they achieve them? What can they do with the abilities they have left? It is easy for people with any kind of disability to believe that the only reason they have problems is because they are disabled. It is necessary to combat that fallacy too. Who doesn't have problems?

One final point: counsellors should have some understanding of the medical condition involved. Probably the best way to achieve this is to talk to the family physician. Counsellors can't be expected to know about the details of various medical conditions, but there are certain things they should know. For instance, is the problem progressive? The writer had a counsellor phone him one day to say that he was having a very difficult time with a client he was seeing who was in a wheelchair as a result of multiple sclerosis (M.S.). He said "At times things are going well and the client is in high spirits. He feels great. At other times he hits rock bottom, gets very depressed, and cries a lot." There is a reason for these changes. Multiple sclerosis is a progressive disease that operates in cycles. There are physiological changes in M.S. that manifest themselves as alternating euphoria and depression. People in the advanced stages of M.S. will plateau and seem to behave "normally". Because the counsellor did not know about the physical and psychological manifestation of the disease process called M.S. he was understandably bewildered by his client's behaviour. The writer explained what he knew about the disease and suggested that the counsellor maintain contact with the client's family physician. If you are dealing with somebody with a physical disability, understand, at least in basic terms, what the medical condition involves. Does it have psychological components or manifestations and, if so, what are they? The client's family doctor is probably your best resource person.

## CONCLUSION

In conclusion, the writer would like to stress that the overall goal of counselling is the same for anyone, whether the person is disabled or not. That goal is to help the clients do the best they can with the abilities they have. It is the writer's hope, that by considering some of the strategies outlined here, perhaps counsellors can come closer to achieving that goal when dealing with a person with a physical disability.

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