The Psychology of Physical Handicap*

A Statement of Some Principles

LAWRENCE EDWIN ABT, Ph.D.

We are in the beginning stages only of our understanding of the factors that are important in the psychology of physical handicap. My experience in working with the physically handicapped has been limited both by inclination and opportunity, and I suggest the following psychological principles in only a tentative way. I believe that they are among the more important principles that may ultimately be developed into a full-scale psychology of physical handicap.

1. *The emotions, desires, and drives of the handicapped individual are not different from those of the normal individual.*

This principle insists that with respect to his intellectual and emotional equipment, the handicapped individual is not different from the normal. The particular means by which desires are satisfied and drives satiated depends to a very large extent upon the personality of the handicapped person, the nature and extent of his disability, and the social opportunities available to him for gratification of personal strivings. There may be more similarity between two individuals, one of whom is handicapped and the other of whom is non-handicapped, than there may be between two non-handicapped individuals.

2. *Under conditions in which the handicap has necessitated prolonged hospitalization and convalescence, repression of the activity drive may occur.*

Most individuals by inclination have a strong activity drive which may, however, become greatly modified through certain personality trends. In the same manner, prolonged convalescence may force upon the physically handicapped an attitude that physical activity is neither possible nor desirable. As a result there may occur a considerable restriction of the physical world of the disabled person which does not find its sanction in incapacity to be active.

3. *Trivial disabilities are often sources of intense conflict.*

As a result of injury, there may occur an increased sensitivity toward and interest in the body. Such an interest may find expression in discovering and magnifying bodily defects which all individuals may be presumed to have. Owing to the increased sensitivity, certain trivial disabilities acquire a degree of importance which may be totally unrealistic but which often serve as means for the handicapped individual to work out personal and social problems to which the trivial disabilities are actually unrelated.

4. *The handicapped resent segregation.*

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* For a more complete statement of this material, the reader is referred to my chapter, "Psychological Factors in the Adjustment of Amputees," in *Human Limbs and Their Substitutes,* edited by P. E. Klopsteg and P. D. Wilson, New York: McGraw-Hill Publishing Co., 1954.

Actually, many physically disabled individuals have ambivalent attitudes. They both want to be treated as normal individuals, and at the same time, need to be treated as handicapped persons. Such attitudes fluctuate, and may be presumed to be a function of the possibilities of realizing certain goals in different social situations. That attitude is likely to be dominant which is calculated to permit the physically disabled most readily to gratify his needs in different social contexts. On the deepest levels of personality, however, it must be presumed that most handicapped individuals have a strong need to identify with all other people. It is this situation which accounts for their resentment toward any efforts at their segregation.

5. *The handicapped resent sympathy but seek understanding.*

Like the non-handicapped person, the handicapped individual feels that expressions of sympathy place him in a position of social and personal inferiority, force him to entertain ideas of inequality and inadequacy, and disturb his level of self-confidence. Hence, most physically disabled persons develop deep resentment when others extend sympathy to them, since they cannot always be sure of the motivies of the other person which have aroused sympathetic expressions. At the same time, in common with all others, they sense a deep need to be understood and fully accepted in the social world.

6. *The handicapped individual is inclined to be lonely, morose, self-conscious, sensitive, and suspicious of the opinions of others.*

For all his efforts at maintaining himself in the social community and identifying fully with the non-handicapped, the physically disabled person finds it exceptionally difficult, just as the non-disabled person does, to see the world through the eyes of someone else whose physical status is different from that of his own. The inability fully to participate empathically in the larger social environment may increase his sensitivity, sense of non-belonging, and suspicion of others' motives and opinions.

7. *Many handicapped do not have an adequate understanding of the physical and mental aspects of their conditions, and are fearful of the possible consequences of their disabilities.*

Because of a lack of sufficient understanding of the meaning of their disabled conditions, many physically disadvantaged individuals impose unnecessary restrictions upon themselves and their activities with considerable loss to themselves and their adjustment to the social environment.

8. *An underlying anxiety, which may be exacerbated by repeated failures growing out of or related to the disability, may become focused on minor ailments.*

This is similar to principle 3 and differs only in the sense that repeated failures tend to build up in the handicapped individual a "psychology of failure" which pervades his whole life and which may cause him to rationalize his shortcomings not only by means of his disability, but also because of other minor ailments which he may have. His attention is thus more readily directed to such ailments, which tend to increase in their importance to him.

9. *Defects of personal appearance give more worry to the disabled than defects which are not readily visible.*

Visible defects catalyze more anxiety for the disabled individual because they tend to have social psychological implications, invite the attention of other persons, and may force the handicapped individual to explain or even defend his physical status.

10. *The sudden trauma of disability may reactivate whatever fears and anxieties are latent within the individual.*

Every person, normal or handicapped, carries with him at all times a number of fears and anxieties which, through learning, he usually manages to handle in such a way that they affect to a minimum degree his interpersonal relationships. Individuals differ widely in the amount of anxiety which they have learned to tolerate and in the extent to which fears and anxieties may remain latent. Under the stress imposed by severe trauma of sudden onset, anxiety and fears, formerly latent and potential, may become overt and actual.

In addition to the above principles, there is a social psychological aspect of physical handicap that it is helpful to keep in mind. At present it is possible to suggest this only in broad outline.

To understand the social psychological problems of the physically handicapped, it is helpful to think of them as members of a group among whom certain loyalties have become established, certain attitudes developed, and for whom certain behavior has come to be appropriate and to have acquired sanction. The physically handicapped may be considered to represent one of the marginal groups in the culture. As a minority group, the physically disabled, as other minority group members, tend to feel under-privileged.

The physically disabled often find it difficult to identify themselves with the non-handicapped, whom they may regard as a group whose lot in life is more fortunate than their own. On the other hand, there are disabled persons who have learned that, although they may discover advantages in identifying themselves with others who are also physically handicapped, such identifications may seriously restrict their activities and social contacts to an extent that leads to personal conflict and frustration.

The status needs of the physically handicapped can perhaps best be understood precisely in terms of their group-membership in a minority segment of the population toward which non-afflicted individuals frequently express ambivalent and strongly conflicting attitudes. Like other marginal group members, the physically disabled tend to develop special zones of sensitivity that are easily invaded, often quite unconsciously, by the non-afflicted. Because of membership in the marginal group, many physically afflicted individuals think of their

LAWRENCE EDWIN ABT

Dr. Lawrence Edwin Abt holds a Ph.D. degree in psychology from New York University. He is the author of numerous articles on clinical psychology and is a Fellow of the American Psychological Association. Dr. Abt is now serving as Director of Human Engineering, Alderson Research Laboratories, New York City and is a consultant to the U. S. Veterans Administration. He was one of the featured speakers at the MOALMA Seminar in New York at which this paper was delivered.

social and personal status as precarious and have learned that because of the very physical limitations that have made them members of the underprivileged group, their social status cannot be materially improved. Among the physically disabled, therefore, it is not difficult to see why there are those who experience deep and painful feelings of social rejection that often they cannot correct.

Living in a subordinate position in our society, the physically afflicted may come to find that many of the normal cultural goals that they are disposed to strive for are inaccessible. A forced change in the level of aspiration of a handicapped person may lead to deep frustration, and the imposition of a ceiling on their position in society may deepen the feelings of membership in the minority group.

There is another important social psychological consideration to which I should like briefly to invite your attention. I refer here to the importance of the attitudes of the physically handicapped person's family toward the handicap or injury and the extension of this feeling to the disabled person as a whole. Sometimes, for example, the rejection of a cosmetically unacceptable injury spreads into a rejection of the person who has suffered the injury, to the great detriment of the disabled individual.

There are many other social psychological factors that deserve our attention and interest, but I have had to omit them in the service of brevity. In conclusion, I would like to mention one, however, that seems to be of transcendent importance — that is, *our attitude toward our client and his disability.* I cannot stress to you too much the importance of our own attitudes in dealing with clients, for the reservations we may entertain, whether verbalized or not to the client, tend to become known to him and to influence significantly his outlook on the future and his attitude toward his own disability.

"What's New(s)"

• Glenn E. Jackson, OALMA's Executive Director, has been appointed a consultant to the Division of Civilian Health Requirements of the U. S. Public Health Service. These consultants represent various professional organizations and trade groups having special interest in the health field. Director Jackson is authorized to pick OALMA members to work with him in advising the Public Health Service which is responsible for "the over-all problem of maintaining adequate quantities of health supplies and *equipment* for the civilian population."

• CONTINUING ITS PROGRAM of acquainting surgeons with the latest developments in prostheses, the *W. E. Isle Company* was host to a group of surgeons at its headquarters in Kansas City last December. This was a forum discussion on prescribing, measuring and fitting prostheses with Lee Fawver and Ted Smith as moderators. The VA Suction Socket and UCLA Upper Extremity films were shown. Later in the week members of the Isle staff presented these same films to groups at the Kansas City Rehabilitation Institute and the University of Kansas Medical Center in Kansas City, Kansas.

• THE LISTING of the *Horn Surgical Company* in the new OALMA Roster should be under the heading "Associate Members." This firm with headquarters in Philadelphia is a manufacturer of trusses, abdominal supporters, seamless elastic stockings and other surgical appliances. Officers of the company include William H. Horn, 3rd, President, John A. McCaffrey, Vice President, and William B. Christy 3rd, Secretary and Treasurer.