

Psychotherapy with Physically Disabled Patients

RUI ARAGAO OLIVEIRA, Ph.D.*

ERIC K. MILLINER, M.D.†

RICHARD PAGE, Ph.D.‡

The psychological sequelae of physical impairments present complex challenges for scientific investigation and clinical practice. This paper explores some of the psychodynamic factors that are relevant to the experience of being physically handicapped, which may either impede or facilitate rehabilitation efforts.

The importance of psychotherapy is illustrated by the case of a female with paraplegia who struggled with an impasse in physical rehabilitation following a medullary stroke. Impediments to progress created by the unconscious countertransference of her care providers are also examined.

INTRODUCTION

Along with the growth in world population, there has been a marked increase in the number of individuals with physical disabilities. Technological advances and improved medical care have increased both the physical survival and functional capabilities of persons with disabilities to a level that would have been unthinkable even a few years ago.

Today, there are more than 500 million people in the world with functional and physical disabilities (10 to 12% of the entire population) (1). Those most thoroughly studied are the ones most severely afflicted. Approximately 1.5 million individuals worldwide have suffered from strokes (2); equating to 6 per 1,000 in the population. About 160,000 amputations per year occur in the United States (3), and the prevalence of amputations is approximately 1.7% in industrialized nations (4). Last year, the worldwide incidence of spinal injury ranged from 9.2 to 50 persons per 1 million population, and there are about 0.5 to 1.5 million new brain

* **Mailing address:** Instituto Superior de Psicologia Aplicada, rua Jardim do Tabaco, 34, 1149-041, Lisboa, Portugal. e-mail: raragao@ispa.pt

† Department of Psychiatry, Mayo Clinic, Rochester, MN.

‡ Department of Counseling, University of Georgia, USA.

injuries per year (5). In the United States, 5.3 million children and adults currently live with disabilities resulting from traumatic brain injury, a little more than 2% of the U.S. population (6).

The impact of disabilities on society extends beyond economic, social, and political dimensions. Although the psychological implications are well recognized, a comprehensive perspective that would allow optimal treatment and rehabilitation has yet to be achieved. Even the classification, "persons with physical disabilities," fails to recognize the complexity and diversity of a patient population requiring individualized care. It would be misguided to believe that such a diverse group could be treated with standardized interventions or that their clinical responses would follow a uniform and predictable course.

The majority of literature on intervention in physical rehabilitation has focused on behavioral approaches. Diller (7) pointed out a fundamental philosophical difference between rehabilitation medicine and psychotherapy. He noted that rehabilitation medicine is action-oriented whereas psychotherapy is insight-oriented, and that this difference could be a challenge to reconcile. Despite a well-established literature on the psychological consequences of physical defects, a more comprehensive understanding has only recently begun to emerge (8).

Regardless of severity, an acquired disability is capable of disrupting normal life and altering the patient's perception of time, space and capacity for rational thought. Acquired disabilities alter the subject's psychodynamic balance by affecting their intrapsychic and interpersonal environments. The patient is confronted by a radically new and different set of conditions, which may dramatically alter previous family, professional and social roles.

The degree of disability and long-term prognosis contributes to the diversity of chronically disabled individuals. From the outset, alterations in self-concept and adaptive functioning may create dramatic shifts in the course of a person's life. Conflicts surrounding new needs for safety and protection may either emerge as immobilizing anxieties and regressive behaviors, or may be externalized, projected and distort the patient's social relationships.

"Loss of capacities" equates to "loss of ego functions" and may destabilize adaptive functioning on multiple levels. In the initial phase, becoming consciously aware of one's disability can threaten one's sense of meaning and purpose, undermine one's sense of bodily integrity, and threaten even one's sense of cohesive personal identity.

In addition, experiencing a disability can challenge one's basic assump-

tions about the world in general. The psychological consequences can be diverse, pervasive, unpredictable and at times catastrophic. The global nature of such change is impressive, regardless of the severity of the physical trauma and the variability of practical limitations that different individuals experience.

Factors most frequently linked with the degree of incapacity include: prior ego strength and developmental maturity (9) (10); current phase of life and past personal experiences (including prior contact with disabled persons) (11); financial and social support (1) (12); and prevailing attitudes about disabilities within the culture (13).

In addition to reviewing psychotherapy as it is considered in the context of physically disabled patients, Grzesiak (11) also highlights areas of importance for clinical work, including issues of loss, mourning and trauma.

As the awareness of being “disabled” is internalized, patients frequently feel “different” from other people. Associated feelings of grief, anger, envy and shame are common, but occasionally disabled persons may also feel a sense of pride, uniqueness or special power or privilege because of their condition. All of these factors play an important role in the patient’s adaptation, and some individuals may view their disability as legitimate grounds for “exemption” from most of life’s obligations and responsibilities.

In fact, acquired physical disabilities place great demands on the psyche. Even if ego defenses are sufficient to contain overwhelming anxiety, alterations in adaptive functioning are often evident as defense mechanisms of denial, repression, projection, reaction formation and regression frequently come into play. In more severely disturbed patients, a profound loss of self-esteem or even identity fragmentation is sometimes observed.

The presence of a disability has a powerful impact on interpersonal relationships. Families often feel overwhelmed and controlled by changes in their emotional environment (real or symbolic) and by shifts in their social connections to extended family and community. Disabled persons often find themselves in a negative environment, grouped with others who have disabilities. This can be dehumanizing and lack value, because of the huge costs in terms of the social, emotional and financial burdens the negative environment creates.

When challenged to adapt to such sudden and radical changes, patients and families turn to health professionals and institutions with virtually “magical” expectations that the condition can be transformed or even

totally erased. At the same time, the patient's positive transferences create expectations of being safe and cared for by doctors, physiotherapists and psychotherapists who they believe are omnipotent in their capacities to heal. The liability is that such positive expectations envision goals for treatment that may be unrealistic and unattainable.

These attitudes and expectations are largely unconscious and involuntary, and are fueled by the intensity of the patient's desire to be restored to perfect wholeness. In addition, patients frequently never doubt the ability of health professionals to accomplish such "metamorphoses" of their being/body, if their care providers are simply willing to do so.

Paradoxically, the most significant characteristic of patients with a chronic disability is their hostility and opposition to any movement toward autonomy. Often they persist in extended treatments, sometimes for years, even though there may have been no evidence of progress for months. In such cases, the patient's psychological inability to accept the reality of their condition may make limited and realistic goals too painful to accept, and consequently their degree of recovered function remains much more limited than their physical disability would predict.

Social repercussions occur when psychological factors inhibit a disabled patient's optimal recovery. The most frequent patterns include regressive behavior in the patient's interactions with family, friends, psychotherapist and members of the treatment team. These patterns are manifest by infantile behavior, excessive dependency, social withdrawal, hostility and occasional aggression. In addition, depressive reactions, and the associated aggression may be either self-directed (a "centripetal" pattern; accompanied by viewing and treating one's self as a "bad-object") or externalized (a "centrifugal" pattern; in which relatives, health care providers, or even rehabilitation equipment/facilities may become the target).

CLINICAL VIGNETTE

HISTORY OF THE PRESENT ILLNESS

Josefina sustained a medullary stroke, which left her paraplegic at age 62. She had been confined to a wheelchair for only three months when referred by her physiotherapist for psychological assessment because of uncontrolled anxiety attacks during the previous months. Her symptoms began following a slow and painful medical examination, and were characterized by crying and a sensation of panic in proximity to hospital equipment or patients who were disfigured or severely disabled; encounters which had not previously disturbed her.

SOCIAL/DEVELOPMENTAL HISTORY

Josefina is the middle sister of five children from a respectable family, originally from a village in the interior of Portugal. When Josefina was only ten years old, her father died from tuberculosis and left the family in financial debt to the local physician. Her mother, a woman with very little education, was unable to maintain the quality of life to which the family had been accustomed. At a young age, Josefina was obligated to work as a dressmaker, and to assist her brothers with chores at home.

Josefina was always the fragile girl in the family and loved by all. As she got older, she alternated living with three of her brothers and helped them with their children and other odd jobs. She “sacrificed twelve years of her life” providing care for a niece with Down’s Syndrome who was subsequently hospitalized and died in an institution.

Against the will of her family (brothers and cousins), Josefina married at the age of 50 to a divorced man who was twelve years her senior. Despite being in poor health herself, she planned to help her husband in educating his two children who were still in elementary school. When the children opted instead to live with their mother six years ago, Josefina felt it was ungrateful on their part. Two years ago, her husband suffered a stroke, which left him with neurological impairments. Josefina’s brothers and cousins reconciled with her some time ago and now her elder and younger sisters live with her in her husband’s house.

PAST MEDICAL HISTORY

Josefina’s history of numerous hospitalizations began in childhood. At the age of two, she was seriously ill with meningitis and thereafter her father referred to her as the “living dead.” Prior to her current illness, a serious car accident in her 50’s broke her legs and resulted in a six-month hospitalization.

CLINICAL COURSE AND DISCUSSION

After a three-month admission, and nine months of clinical rehabilitation, the physical therapy was terminated against Josefina’s will, because of her lack of progress. After she started walking with crutches, she stopped practicing at home and reverted to using a wheelchair. However, her psychotherapist was motivated to persist with her treatment, feeling she was “the only one who had not abandoned the patient.”

Her face-to-face psychotherapy took place at the rehabilitation service of a publically funded general hospital for more than a year. She was an inpatient for two months, after which she lived at home and received weekly ego supportive, nondirective psychotherapy for over another year.

Her insights in psychotherapy reawakened situational anxieties, and gradually led to working through of past traumatic memories, as well as her intense ambivalence about her current physical limitations.

Josefina's case illustrates the frequent uncertainty of initial medical prognosis. Some patients may totally recover, while others remain markedly impaired. But in most cases, the patient selectively attends to only the optimistic possibilities, attempting to sustain their hope for recovery even at the expense of being less objective in their understanding.

Initially, Josefina seemed resigned to being in a wheelchair. But after her physical therapy was terminated, she gradually acknowledged having not been convinced that her limitations would prove to be permanent. In the midst of tears and depressive affect, she verbalized her thoughts that she did not deserve her situation, and her feelings that she has been cast aside both at home and at the hospital.

At first, she was adamant that her physiotherapy needed to be resumed. Then, after taking stock of her situation, Josefina made an admirable attempt to (re)find herself, despite her current circumstances. With the help of her psychotherapist, she recalled that for eight out of nine months, her treatment had been virtually at an impasse. Then, in the concluding 30 days, Josephine accomplished numerous significant changes.

Accepting the reality of her physical limitations altered Josefina's mental self-representation and her previous assumptions about her own independence. In addition, she had to modify her view of herself as a care-taker within her family. By doing this she made a change in conscious and unconscious self and object relationships which was prerequisite for her optimal physical recovery.

During this period she was able to bring to her husband's attention the anguish she had felt in aiding others, with great sacrifice and without compensation. She recalled to her own astonishment an occasion when she demanded a revision of her husband's will, after she realized it was unfavorable to her. This was a period when Josefina had the ability to take a firm stand for and within herself. It was also during this time that she made great progress in her physical rehabilitation; undoubtedly due to her consistent effort with exercise training at home.

One of the great pleasures she continues to have is leaving home and going to the hospital to speak with doctors, therapists, nurses, and of course her psychotherapist. These are people who have contributed or continue to contribute to her recovery, and upon whom Josefina continues to feel dependent.

In the end, Josefina does not want to lose contact with them, or be forgotten. She explains that once again she has been called upon to look after her loved ones (brothers, husband, and stepchildren). Amazed by her own transformation, Josefina has resumed a role compatible with her ego-ideal which is purposeful, adaptive, and self-affirming. In spite of her neuromuscular limitations, she has improved her independent self-care and skills of daily living, including bathing, dressing, toileting and being mobile in a wheelchair on her own.

In psychotherapy, issues of loss force patients like Josefina to construct a new self-representation. The rupture of previously well-established constructs of both body image and sense of "self" can be expected to leave patients feeling confused and dysphoric; and the loss of those original self-representations need to be mourned. At the same time, patients must focus upon and consolidate those defining characteristics of their identity, which will endure despite the permanent alterations in their physical capacities and body image.

The process of redefining and synthesizing a new, cohesive sense of self is typically accompanied by two types of affect: 1) mourning of reality-based losses, which may be accompanied by depressive symptoms; and 2) mildly euphoric feelings as a new self-representation becomes well established. Clinical observations (1) demonstrate that the degree of physical impairment and even the amount of disfigurement is not the most predictive factor, but rather it is the ego-strength and psychological capabilities of the patient which determine the success or failure of this process. Those patients who suppress or attempt to omnipotently deny any awareness of depressive affects often betray their distress through behavioral enactments with family and friends. Clinical investigations have confirmed that such patients are so constricted by their disability and the task of staying alive that they have lost touch with their own affective experience and creativity (1) (14). Their imagination is neither stimulated nor stimulating for those around them.

Patients who are constrained in this way are frequently concrete in their thinking, very narrow in their focus and range of interests, and worried about minutiae. In the initial phase of their psychotherapy, they are preoccupied with the here-and-now; resist explorations of the past and future; and are rigid and inflexible in their defensive posture.

These patients are understandably limited in other ways. They are limited by their incapacity to tolerate frustration; and by their inability to contain and work through the destructive fantasies and impulses kindled

by the reality of their physical disability. They are also limited by their lack of resilience when struggling to cope with castration anxiety and narcissistic injury.

For those who face and work through the depressive position, a creative capacity often emerges to redefine new and different roles in their lives—transforming the internal world from within and giving life a new meaning, despite the presence of external realities that cannot be changed.

Josefina's case illustrates how being disabled is frequently accompanied by apathy, perceived helplessness and dependency upon the treatment process; and a defensive avoidance of self-reflection since the very act of thinking has become a painful experience. Psychic survival and successful rehabilitation necessitates reversing this aversion to self-observation and accessing an openness to relearning new views of one's bodily sensations and emotional experience.

During the initial phase of treatment, Josefina maintained a defensive position by splitting off and disavowing the negative aspects of her body image. But when confronted with outside reminders of disability in other patients, her denial shattered, and she plunged into despair and confusion.

Early in treatment, Josefina maintained the belief that her doctors and the treatment program would omnipotently and magically restore her physical abilities. At an unconscious level, physician and patient colluded to support each other in the fantasy that a thorough resolution of Josefina's disability would eventually be achieved. In the patient's mind, the "doctor" and "treatment" were linked together in creating and sustaining the conviction that her full recovery was inevitable.

Because Josefina needed a wheelchair and feared that her disability might be permanent, she was prompted to think of her physical illness as an enemy against which she must either defend herself or flee. This frame of mind was further supported by the physiotherapist depicting "treatment" as though it were an external "object" which could change everything. The doctors' need to believe in the patient's improvement, despite the lack of objective progress, prompted several changes in physiotherapists. This added further to the disabled patient's belief that the cause and solution for her problem was "outside" of herself.

When "treatment" occurs away from the patient's personal environment, the perception is reinforced that the physiotherapist possesses some "thing" different from the patient's own resources and that "cure" will be provided from "outside," as if by "magic." In these ways, omnipotent transference expectations of the doctor, physiotherapist and "treatment" are reinforced.

It is this idealizing transference, rather than reality-based expectation, which accounts for patients intensity of relationship to health professionals. Consequently, the unconsciously idealized relationship is misperceived as assuring positive changes in both mind and body.

Because expectations for a positive outcome are so strongly linked to an idealized transference, patients with chronic illness tenaciously resist any movement toward self-sufficient functioning that would place their relationship to health professionals at risk. Consequently, genuine improvement comes to be internally experienced as threatening and treatment often stagnates after four to six months when the goal shifts unconsciously from "continuing progress" to "preserving the treatment relationship." Then, treatments sometime persist for years without further meaningful change.

Facing the reality of permanent limitations may also be too painful and frustrating for patients to tolerate; contributing further to their inability to make further progress.

Transformations, when they do occur, take place on multiple levels and require a change in the patient's orientation to both mind and body. The patient needs to realize that "treatment" depends upon accessing potentials within themselves, rather than being provided a "magical cure" from outside. Only then can the "magical" expectations of an idealizing transference be relinquished in favor of a collaborative effort with the treatment team.

When Josefina started demanding a place for herself and evidenced improvement in her self-esteem, she also developed more adaptive connections and physical interactions with other people. These transformations in both mind and body allowed her to put forth an optimal effort and to resume genuine progress in the rehabilitation program. Improved comprehension, insight, and containment of dysphoric affects were all important to her overall progress, but freeing her mind from neurotic fantasies and inhibitions was the most significant prerequisite for Josefina's recovery.

The therapist's countertransference is of central importance in the treatment of individuals with disabilities. The emotions easily awakened by individuals with physical defects can induce attitudes which unconsciously may become major impediments to the treatment process. Much of the debate around the psychotherapy of the physically disabled actually is a function of countertransference and fear, conscious and unconscious, of disability and difference (11). For example, the psychological regression

and compromised autonomy of the disabled patient may elicit a paternalistic attitude in the health professional, and risk promoting greater dependency than is necessary or helpful, predominantly at an unconscious level. Alternatively, therapists may struggle with unconscious guilt when their actual achievements fail to measure up to the patient's transference expectations of magical and omnipotent solutions.

But the most frequently difficult dimension of psychotherapy with physically disabled individuals is the therapist's struggle to face and cope with the amount of reality-based, physical deficits that affect their patients. Sometimes the intensity of physical suffering or the degree of disfigurement is so devastating that the therapist has difficulty focusing on anything else. The therapist's own castration anxiety may also be unconsciously aroused to the point of distorting professional judgment about the patient's prognosis.

Yorke (10) categorized patients with disabilities who undergo psychoanalysis into three fundamentally different groups. First, there are those "whose physical disability is hypercatheted and becomes a physical coat-hanger on which to put a whole psychopathological wardrobe." A second group consists of those who seek analysis for reasons that appear to have *nothing whatsoever to do with their disabilities*. Yorke (10) (11) cautions that it is dangerous to assume the disability has nothing to do with the patient's problems. Such an attitude involves colluding with the patient to maintain a split in body and self image. The third group consists of those who enter analysis with no physical disability but acquire one along the way. Each of these groups present the psychotherapist with different technical difficulties. Countertransference, and other psychoanalytic concepts, can add important and vital dimensions to understanding the psychotherapeutic process with disabled persons.

Contrary to some author's assertions (15), we question whether psychic reality is more powerful than objective reality. What we do know is that psychic reality can both potentiate mental growth on the one hand, and can create major impediments to the therapeutic progress on the other, especially when the impasse is caused by unconscious countertransference attitudes in the therapist that remain unaddressed.

Everyone currently treating disabled patients has encountered this risk, and anyone new to the field should keep these principles in mind! Once a psychologically informed approach is taken in rehabilitation medicine, professional understanding and treatment goals immediately extend beyond consideration of just the physical disability.

SUMMARY AND CONCLUSION

Within the last decades, health care interventions have been more productively attuned to actualizing the potential for optimal recuperation of every patient. Unique and important contributions of psychotherapy to this effort include: 1) A formulation which synthesizes an understanding of clinical behaviors, reality-based physical limitations and risks with an appreciation of the patient's mechanisms of defense, ego strengths and weaknesses, and transference expectations which impact the treatment process; 2) The utilization of individual psychotherapy (focused on "insight") in combination with supportive individual and group experiences. For children and adolescents struggling with age-appropriate physical-developmental and social issues or learning disabilities, a psychoeducational approach for disabled youngsters has proven very beneficial. 3) Occasional crises occur which involve the spouse or relatives more than the index patient. Working to provide supportive Couple or Family System intervention is sometimes as essential as caring for the disabled individual. 4) Numerous Group Therapy approaches have proven efficacious. Treatment in a group setting is attractive to those who are concerned about cost-containment. Unfortunately, groups for disabled persons are often "didactic" and utilize a format that provides factual information about disabilities, medical procedures, and sometimes an intellectual discussion of "emotional answers" for certain types of problems or conditions. Groups that facilitate self-disclosure and emotional interactions among the members accomplish more meaningful results.

In conclusion, we wish to emphasize the importance of developing rigorous scientific research in the area of disabilities which will match the excellence of clinical work already being done in the field. Gaining an accurate and more thorough understanding of the psychological reality of a disabled person's internal world may be a key to facilitating his or her self-esteem and optimal adaptive functioning.

REFERENCES

1. Oliveira, R.A. (2001). *Psicologia clínica e reabilitação física* Lisbon: Edições ISPA.
2. Spencer, K.A., Tompkins, C.A., & Schilz, R. (1997). Assessment of depression in patients with brain pathology: the case of stroke. *Psychological Bulletin*, 122(2), 132-152.
3. Williamson, G.M., & Walters, A. (1996). Perceived impact of limb amputation on sexual activity: a study of adult amputees. *The Journal of Sex Research*, 33(3), 221-234.
4. Maitre, M., Rouyer, A., Enjalbert, M., & Pélissier, J. (1996). Approche épidémiologique des amputés du membre inférieur. In P. Codine, V. Brun et J.M. André (Eds.). *Amputation du membre inférieur appareillage et rééducation* (pp. 1-7). Paris: Masson.
5. Kraus, J., McArthur, D., Silverman, T., & Jayaraman, M. (1996). Epidemiology of brain injury. In

- Raf Narayan, James Wilberg & John Polvlislock (Eds.). *Neurotrauma* (pp. 13–30). New York: McGraw-Hill.
- Mukherjee, D., Heller, W., & Alper, J.S. (2001). Social and institutional factors in adjustment to traumatic brain injury. *Rehabilitation Psychology, 46*(1), 82–99.
 - Diller, L. (1966). Psychotherapy in rehabilitation. In Proceedings of the International Society for Rehabilitation of the Disabled. Wiesbaden, Germany.
 - Castelnuovo-Tedesco, Pietro (1981). Psychological consequences of physical defects: a psychoanalytic perspective. *International Review of Psycho-Analysis, 8*, 145–154.
 - Li, Li, & More, D. (1998). Acceptance of disability and its correlates. *The Journal of Social Psychology, 138*(1), 13–25.
 - Yorke, C. (1980). Some comments on the psychoanalytic treatment of patients with physical disabilities. *International Journal of Psychoanalysis, 61*, 187–193.
 - Grzesiak, R., & Hicok, D.A. (1994). A brief history of psychotherapy and physical disability. *American Journal of Psychotherapy, 48*(2), 240–250.
 - Wilcox, Victoria L., Kasl, S.V., & Berkman, L.F. (1994). Social support and physical disability in older people after hospitalisation: a prospective study. *Health Psychology, 13*(2), 170–179.
 - Meyer, L., Gouvier, W.D., Duke, M., & Advokat, C. (2001). Influence of social context on reported attitudes of nondisabled students toward students with disabilities. *Rehabilitation Counseling Bulletin, 45*(1), 50–52.
 - Pierre, P. (1996). Aspects psychologiques et psychiatriques de l'amputation du membre inférieur et de sa prise en charge. In P. Codine, V. Brun et J.M. André (Eds.). *Amputation du membre inférieur appareillage et rééducation* (pp. 443–450). Paris: Masson.
 - Lussier, A. (1980). The physical handicap and the body ego. *International Journal of Psychoanalysis, 61*, 179–187.

Copyright of American Journal of Psychotherapy is the property of Association for the Advancement of Psychotherapy and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.