CHAPTER - IV

INTERPRETATION AND DISCUSSION

PART ONE

4.1   The Effect of the Type of Limb-Injury and
        Amputation on Crisis Experience.

4.2   The Effect of the Disability-Causing Situation
        (Accidents or illness and War) on Crisis
        Experience.

4.3   The Effect of the Differential Patterns of the
        World Hypotheses on Crisis Experience.

4.4   The Effect of the Dominant Value-Types on
        Crisis Experience.

PART TWO

4.5   The Effect of the Type of Limb-Injury and
        Amputation on the Problems of Adjustment.

4.6   The Effect of the Disability-Causing Situation
        (Accident or illness and War) on the Problems
        of Adjustment.

4.7   The Effect of the Differential Patterns of the
        World Hypotheses on the Problems of Adjustment.

4.8   The Effect of the Dominant Value Types on the
        Problems of Adjustment.

4.9   The Psychological World of the Disabled : An
        Overview.

PART THREE

        THE REHABILITATION OF THE PHYSICALLY DISABLED PERSONS

4.10   The Need for Rehabilitation of the Physically
        Disabled People.

4.11   The Goal of Rehabilitation

        (a)   Physical restoration

        (b)   Psychological restoration

CHAPTER - IV

INTERPRETATION AND DISCUSSION

PART ONE

The present investigation aimed at studying the crisis experience and adjustment of the physically disabled people.

4.1 The Effects of the Type of Limb-Injury and Amputation (Leg and Arm) on Crisis Experience.

The results have shown (Table 1) that there is a greater degree of crisis experience among the arm-amputed people than that among the leg-amputed. This may be an outcome of several possible reasons. The hand is perceived as a vehicle for social interaction. It helps one in nonverbal communication while interacting with others. It also facilitates in social sanctions, for example, all social interactions and negotiations are done with hand. Significance of the hand has been described through various metaphors such as 'lending a hand', 'giving a hand', and so on. Therefore, the loss of hand makes a person feel miserable as it restricts his free participation and interaction in life. Consequently, the arm amputee may feel that his self-esteem is reduced.

An understanding of the psychological situation that leads to the differences between the arm-amputed and the

leg-amputed must precede the understanding of differences between the two groups in crisis experience. A person faces himself with his needs, abilities and aspirations. But the disabled person's coping abilities are inadequate to meet these demands (Fink 1967, Miller and Iscoe 1963) and consequently, experiences crisis in adjustment.

The incompatibility between the disabled person's physical situation and the mental picture heh holds of himself also accounts for the differences in crisis experience. Among the other reasons for the arm-amputed people having more intense crisis experience than the leg-amputed people could be the greater visibility of the arm-stump that may lead to a greater sense of inferiority and inadequacy. At the earlier stages of the injury (Shock and Denial) perhaps the body image is more potent than perceptions and, therefore, the rejection of perception may be incompatible with their self-image (Stubbins, 1977).

Visible physical disability is perceived as one of the barriers in marriage or matrimonial affairs. There are ample experimental evidences that the persons with physical disabilities are quite frequently restricted from participating in social and recreational activities (Rusk and Taylor 1946).

However, at the 3rd phase (Acknowledgement) the leg-amputed people seem to have more intense crisis experience

(Table 1) than the arm-amputed people which could be explained as a reaction against their earlier rejection of the injury (Phase 2).

Surprisingly enough the findings also indicate that the leg-amputed people are more open to help from others. This may be because they have to depend on other people for their locomotion and interaction. So they do need help for their day to day affairs like taking help to sit in a wheel-chair. It may be therefore, their higher degree of dependence by that causes greater emotional crisis.

However, for the arm-amputed people the help situation is not always so comfortable. They are resistant to seek and accept help from others. The general stigma attached to the disabled people as "helpless" make them deliberately and nega-tivistically resistant to help seeking behaviour.

4.2 The Effect of the Disability-Causing Situation (Accident or illness and War) on Crisis Experience.

The results showed that the War-disabled people had greater degree of crisis experience i.e. disturbed reality perception etc. than the disabled civilians (Table 2). It could be because of the following reasons.

The intensity and the extensity of horror involved in a War situation is much greater compared to that in accidents or illness. The attitude of the War disabled persons toward their disability is very different from that of the disabled civilians. The soldiers could not escape from the dangerous situation they were exposed to because of their commitments. Hence, the disability is looked upon as something that is forced upon them by the mature of their job commitments. So war accident has a completely different connotation. Among the other reasons of their having more intense crisis experience, one could be the limited nature of their interaction with the outside world as army men. Therefore, in addition to their disability which imposes limitations for employment, their lack of knowledge about job opportunities is itself a serious disadvantage when compared to the disabled civilians.

The findings also showed that the disabled civilians experienced greater degree of crisis in the first phase (shock) compared to that of the War-disabled. This could be accounted for by the sudden loss of independence they had always enjoyed as free citizens in comparison with the restricted life-style of the soldiers. Or, it could be that the awareness of the sudden less plunges them into a state of acute distress. This may be accompanied by feelings of worthlessness and inadequacy in facing life. They may feel as if everything is lost and cannot achieve any of their life goals, and thus they may tend to resign themselves to a dependent existence.

4.3 The Effects of the Differential Patterns of World Hypotheses on Crisis Experience.

The greater degree of crisis experience shown by the Formists and the Mechanicists (Table 3,4,5and 7) as compared to the Contextualists and the Organicists could be because of their tendency toward analytical approach. They (Formists Mechanicists) question themselves, "Why me?" or "Why me the unfortunate?" after being disabled. The very nature of the logic underlying their questioning troubles them and hurts them deeply. Among the other possible reasons of their having more crisis experience one could be that they are very perfect-ionist, and with the changed badly-condition and the dis-ability, they cannot carry on with the same perfections in their activities,and hence the greater crisis experience. The more intensity of their (Mechanicists) crisis experience also could be due to their mechanical apptitude, as the mechanici-sts view the whole world as if it were a great machine. A machine can be repaired and put to work again after a break down. But regarding themselves, the disability is permanent and they cannot alter the situation however hard they may wish it.

Psychologically, the very incompatibility between their (Mechanicist and Formists) physical situation and the mental picture that they hold of themselves give rise to

greater crisis experience. For example, one of the mecha-
nicists said during an interview, "Only if I could be
normal again".

The Formists, however, deal with the _what_ of the
events. After being disabled they tend to think of what they
can do to overcome. it. The greater intensity of their crisis
experience could be because of their tendency to compare and
contrast their present condition with the past. This perce-
ption of their own selves further gives rise to feelings of
incompleteness and uncertainty about life, and thus the
greater crisis experience.

The less degree of crisis experienced in the Organi-
cists (Table 6) and the contextualists (Table 7) could be
due to their ability to look at events in a more positive
ways. Another possible reason could be their ability to empha-
size the interconnectedness and dependence of different events
upon one another. They also tend to look upon their disability
as a transitory phase. They are often heard reporting, "If I
am unable to perform certain activities today, never mind,
may be tomorrow I will be in a position to perform them".
Therefore, it is infered that their tendency to view their
own disability in a more positive way reduces the intensity
of their crisis experience.

4.4 The Effects of the Different Dominant Value-Types on Crisis Experience.

The tendency toward greater degree of crisis experience in the people with dominant social and political values (Table 9) compared to those with dominant aesthetic, theoretical, economic and religious values might be due to the less acceptance of the disability. It is naturally a very desirable thing for an individual to possess an intact and energetic body, and in the absence of any of his body part he may not accept himself fully as the body is considered the manifest aspect of one's personality. Thus, the loss aspect dominates the emotional stage which might give rise to more intense crisis experience.

The highest value of the social person is love of people whether of one or many (Chapter-II). For instance, one of the subjects (Social Group) stated, "People might laugh at me and not stand my presence or accept me as they used to in the past". Their fear of rejection by others may be a contributing factor to their crisis experience.

The feelings of being socially inadequate are more prevalent in the people with dominant social values and that might be a reason for their having more crisis experience. The disabled persons suffer from severe restrictions of employment opportunities and encounter considerable

difficulties in carrying on a normal social and vocational life. They may even find that certain social prejudices may bar them from the world of work. They may also be perceived and treated as members of the derogated class and not as unique individuals. All these contribute to their crisis experience.

Another possible reason for the greater crisis experience in people with social and political values may be because they are public persons. The more they are with people, the more they may be reminded of their disability. Also, any special consideration shown to them by others may occasion feelings of self pity. If the disability is severe, they may be cut off from their former social interactions which may also contribute to their greater crisis experience.

The relatively less degree of crisis experience in the people with theoretical, economic, aesthetic and reli- gious values (Table 9) could be because they generally tend to have a very different philosophy of life. They basically believe in harmonious relationships. This type of positive approach toward life nutralizes the impact of negative exp- eriences in life and this promotes their proper growth in various areas of adjustment.

PART TWO

4.5 The Effects of the Type of Limb-Injury and Amputation on the Problems of Adjustment.

Adjustment demands interaction with and participation of the people in their surrounding environment and both of these require adequate anatomical and functional intactness of the limbs. In the absence of any limb such as the arm or leg, whether partially or completely, the individual faces the barrier imposed by the absence of the body intactness or physical adequacy.

(a) Type of Limb-Injury and Home Adjustment:

Results revealed no significant differences between the leg and arm-amputed groups (Table10) in regard to home adjustment. Both showed high degree of maladjustment (Table 10). This could be due to the higher incidence of mal-adjustment in both the groups. The disabled, for example may express maladjustment through bodily malfunctioning. His relationships with different family members may fail to gratify his psychological needs for ~~example~~ love and affection. Occasionally he may experience conflicting moods of love and hate for some of the family members. A probable reason for his maladjustivebehaviour at home may be that he feels lâck of acceptance by the family members. He may also be reject-ing his dependent state interiorly.

(b) <u>Type of Limb-Injury and Health Adjustment</u>:

The higher incidence of very unsatisfactory health adjustment of the Leg amputed and the Arm amputed groups (Table 11) could be due to the major surgical operations that affect the general physical health of the person. A healthy appearance and health both are important sources for the person's sense of security in life. An individual's personality structure has implications for physical health and his unsatisfactory adjustment to health could also be due to the unhealthy reactions to the disability. It may also be that the persons disability interfers with his capacity to find meaningful satisfactions in life. The arm-amputed group have shown less adjustment as compared to the leg-amputed group. This could be attributed to their greater crisis experience than the leg-amputed (Table 1).

(c) <u>Type of Limb-Injury and Social Adjustment</u>:

The higher incidence of social adjustment in leg-amputed and arm-amputed groups (Table 13) could be due to the healthy acceptance of the reality of the loss of limb. Although a person's overall capacity to come to terms with his environment has been reduced as a result of his disability, it does not get eliminated completely. Most of the basic functions which an organism is required to perform are still possible with reduced overall competence. Thus, a

leg-amputee can still locomote in his environment though
he may have to use a wheel-chair or limp with his prosthesis.

(d) <u>Type of Limb-Injury and Emotional Adjustment</u>:

The high percentage of persons from the leg-amputed
and the arm-amputed showing very unsatisfactory level of
emotional adjustment (Table 14) might be due to depression
and anxiety about the future. According to Hadfield (1961)
once the crippling disability has afflicted a person it is
very natural that his life will be thrown into some sort of
chaos. The person perceives his plans for the future as being
disrupted. Following the disability the individual may per-
ceive his life empty and futile. For example a painter who
earns his living and gains or derives satisfactions from his
paintings, gets overwhelmed with depression when his funct-
ional handicap necessitates giving up his painting activity.

(e) <u>Type of Limb-Injury and Occupational Adjustment</u>:

The higher degree of occupational maladjustment in
the arm-amputed as compared to the leg-amputed (Table 15)
could be due to the high incidence of their crisis experi-
ence (Table 1). An analysis of the response patterns seem
to suggest that the more frequently occuring symptoms of
occupational maladjustment in the arm-amputed group are the
fear of losing the present job,worry because of the inability

to meet the financial obligations, uncertainty about future prospects of gaining job and promotions, the feelings of fatique and so on, as compared to those in the leg-amputed group.

Conceptually, whether the disability is functional or cosmetic, the afflicted person is at a great disadvantage, and faces many unnecessary problems in striving to adjust to the vocational demands and his society at large (Shontz 1971 Asch 1952, Dembo 1969).

The more maladjustment in the arm-amputed people could be due to their denial of the injury as has already been discussed in connection with crisis experience (4.1 and 4.2). Their feeling of loss is not only physical but also psychological and may lead to more maladjustment in different life spheres. Dembo (1969) described that the injured felt the loss of status as a normal being in the devaluative attitude of the 'fortunate' to the 'unfortunate'. The disabled individual faces problems of adjustment especially because he feels that he is not accepted as equally worthy by his peer groups, subordinates and others in the society of which he is a member.

4.6 The Effect of the Disability-Causing Situation(Accident, Illness or War) on Problems of Adjustment.

(a) Type of the disability causing situation and home adjustment.

The greater incidence of maladjustment in the War-disabled compared to the disabled civilians (Table 17) in regard to the home adjustment could be due to (i) the separation from their families. It is speculated that the family plays a very significant role in rehabilitating its disabled member, but the present study included most of the subjects who were rehabilitated by the Government and due to thistbhey (War disabled) were isolated from their families. Many of them have expressed hopelessness of life in the absence of love, affection and also some degree of self-sufficiency or autonomy. (ii) Another reason may be - and this has been expressed by many in the interviews, that the pension they receive is inadequate to meet their bare requirements.

(b) Type of the disability-causing situation and health adjustment

In regard to health adjustment the war disabled showed poorer level of adjustment as compared to the disabled civilians (Table 18). An analysis of some of the interview reports with the war disabled revealed that the more frequently occuring symptons of maladjustment were (i) the indirect

effect of War Situation. The War-disabled people are occa-
sionally troubled by skin eruptions such as carbuncles or
boils, and those who had to live in ice during the war-time
experience less skin sensitivity (ii) With the lack of
nutrious food they become anemic and some of the subjects
said that they required frequent medical attention. All these
reasons might account for their poor health adjustment.

(c) Type of the disability-causing situation and social
    adjustment.

The War-disabled people were found to be more socially
maladjusted as compared to the disabled civilians (Table 19).
Some of the symptoms as revealed by the war disabled were
'feeling self-conscious in the presence of other persons' and
'withdrawal from the social gatherings'. For example, some of
the subjects confirmed when asked in the interview whether
they kept themselves in the background in socials. Many of
them were also driven into levels of life far below any stand-
ard of ordinary fulfilment or achievemgnt. This could be
explained in terms of the role theory. Parsons (1958) explain-
ed that illness or disability disrupts the established role
patterns and leads to reorganization of the roles.

(d) Type of the disability-causing situation and
    emotional adjustment.

The higher incidence of emotional maladjustment in

the war disabled as compared to the disabled civilians
(Table 20) could be due to (i) the more crisis experience
that they had after they had become disabled (ii) some of
the symptoms frequently occuring in the war disabled people
were seem as 'ups and downs in mood','worrying too long over
humiliating experiences and misfortune','troubled feelings
of inferiority' and 'getting hurt'. These often made them
feel miserable. These difficulties that they faced necessarily
gave rise to more emotional maladjustments and this could be
the reason for their lack of emotional maladjustment.

(e) Type of the disability-causing situation and occupational adjustment

The higher incidence of more occupational maladjustment
in the war disabled people as compared to the disabled civi-
lians (Table 21) could be due to : (i) the forced retirement
of the war disabled people from their jobs. An analysis of
the interview reports of the war-disabled subjects suggested
that their occupational maladjustment was mainly due to
their forced retirement, these people were considered to be
'misfit' in their jobs and therefore most of them were forced
to retire. This left them feeling very angry about it and
they formed negative feelings about themselves, as one of
them remarks, "you see, now I am good for nothing and we
military wallas are pushed out of the jobs when we become
disabled".

4.7 <u>The Effect of the Differential Patterns of the</u>
<u>World Hypotheses on the Problems of Adjustment.</u>

The impact of loss which the disabled individuals
experience produces sufferings and difficulties. As Dembo
(1948) also stated that the overcoming of psychological
suffering whether or not it threatens mental illness, is a
problem of adjustment.

(a) <u>The differential patterns of the world hypotheses</u>
<u>and home adjustment</u>

The contextualists showed higher incidence of maladju-
stment at home (Table 23) compared to the Formists, Mechani-
cists and the Organicists. This could be due to the earlier
denial of their injury. Also, they perceive the things in a
different light, as they see the interconnectedness of the
different events taking places (Pepper, 1942). Anything
happening against their wishes, they might contribute that
failure to their disability. Thus they become more prone to
adjustment problems. This could be explained in terms of
spread phenomenon. (Wright 1960, Asch 1962, Dembo 1953).

(b) <u>The differential patterns of the world hypotheses</u>
<u>and health adjustment</u>

The higher incidence of average level of health
adjustment in the dominant organicists (Table 25) could be

due to the philosophy of life that they hold, that is, they try to understand the different events as parts of within a whole (Pepper, 1942). Thus the organicist can neutralize the negative experiences and maintain balance adequately. Another possible reason of their having less problems of adjustment could be the less degree of crisis that they experienced.

(c) The differential patterns of the world hypotheses and social adjustment

The higher incidence of social maladjustment as indicated by the contextualists (Table 27) could be due to their tendency to link every event or incident that takes place. For example, they feel that because of their disability they cannot do anything worthwhile. They consider it as a big barrier in their way. Some of them are painfully aware of being declassed, considered helpless, of being patronized and of losing their friends. Race (1972) wrote of the disabled as having to become accustomed to "a life-style of fear, frustration, failure and even despair". Many of the subjects interviewed did not confirm the statement when asked, if they were sometimes the leaders at social functions.

(d) The differential patterns of the world hypotheses and emotional adjustment

The more emotional maladjustment in the contextualists

(Table 29) than the Formists the Mechanicist and the
Organicists may be due to (i) the social isolation : their
limited mobility and feelings of inferiority. (Race, 1972)
may occasion emotional disturbances. They exhibit symptons
like getting upset too easily and of being nervous. Many
of them responded positively to the question whether or not
they get hurt easily (Bell adjustment inventory). Among the
other reasons could be (ii) their ability to relate things
to one another. The contextualists may feel frustrated or
helpless as they fail to see the interconnectedness of things.
They suffer all the more because they fail to see the meaning
or reason for their suffering.

(e) The differential patterns of the World hypotheses
and occupational adjustment

The higher incidence of average occupational adjustment
in the organicists (Table 31) could be due to their (i) prim-
ary emphasis on understanding the parts only within the wholes
(ii) They see the world as an organism rather than a machine
(Pepper 1942). Their positive self perceptions might promote
their adjustment in interpersonal relations and consequently
in their occupations.

4.8 The Effects of the Different-Dominant Value-Types
on the Problems of Adjustment.

The analysis of the data for the different dominant

value groups obtained from chi-squares (Table 64, 66, 68, 70, 72) and F-values (Table 65, 67, 69, 71, 73) and revealed no statistically significant differences in any of the areas of adjustment i.e. home, health, social, emotional and occupational.

When a person suffers from some kind of affliction which results in a handicap it may leave the individual with certain devastating effects (Shontz 1970). It may be said that the disability imposes extra burdens upon the sufferer and this renders him more vulnerable to adjustmental problems. Sometimes the effects of disability may not only be due to the disability alone, but also be due to his interaction with others in the social milieu and this could be explained in terms of the interpersonal theory. These might be the reasons for the nonsignificant differences among the various value types in regard to the problems of adjustment. Among the other reasons the various dominant values seem to have no differential impacts, since all of them have a common physiological dispositional predicament, i.e. disability. And the disability seems to impose or demand a particular kind of life style over and above the life style that has evolved in different individuals.

(a) <u>The effect of different dominant value-types</u>
<u>and home adjustment</u>

Unsatisfactory home adjustment in the people with
dominant theoretical values (Table 64) could be due to their
tendency to compare the past with their present state, which
makes them more miserable. It could also be due to the added
stress and strain (Cowen 1961).

(b) <u>The effect of different dominant value-types</u>
<u>and health adjustment</u>

The deterioration in health (Table 66) could be due
to the impact of physical disability leading to functional
inability. A few traditional theories also lend their support
to this view. Some of the subjects complained about the
difficulty in getting sleep even when there were no noise to
cause disturbances. The feeling of pains in the phantom body
parts might be another factor that aggrevates the health
problem (Shontz, 1971). The individual experiences sensations
from the phantom body parts.and when he reaches it for
instance, to scratch it, he finds that it is not there. The
extended phantom feels as though it protrudes beyond the
point of amputation (Shontz, 1971). These experiences may
lead to more problems of health adjustment.

(c) <u>The effect of the different dominant value-types</u>
<u>and social adjustment.</u>

The greater incidence of average social adjustment of
the dominant Economic people (Table 68) could be because of
their "practical nature", and their interest in utilizing the
opportunities that are available to them. An individual of
this type tries to take fairly good care of his health. and
has adequate concern for the body needs and when he observes
himself becoming excessively fatiqued he rests. The body is
perceived as a vehicle for all social interactions. Concept-
ually these people are very pragmatic and they seem to make
most of whatever they have and arrange their life in accord-
ance with the remarking abilities (Singh and Sharma). Thus it
may be said that because of their coping abilities they are.
less prone to be affected in their social adjustment.

(d) <u>The effect of different dominant value-types</u>
<u>and emotional adjustment.</u>

In regard to the emotional adjustment though no
significant differences were obtained in the people with
differemtial value patterns (Table 70), the higher degree of
emotional maladjustment in the dominant theoretical people
could be because of the empirical, critical and the rational
approach that they have toward life (Singh and Sharma). In
the sheer act of comparing the present with the past they

are prone to have more problems of adjustment. Their sense
of loss predominates and they see their loss as a main
feature of present. Dembo (1958) stated that an individual
sees his loss in terms of his personal and social satisfa-
ctions which he feels are now denied to him. It is only
when an individual realize that a difference exists and he
compares that present state with that of past, that he feels
disturbed.

(e) The effect of different dominant value types
    and occupational adjustment

The higher incidence of occupational maladjustment in
the dominant ssocial value group (Table 72) could be explained
keeping in mind, (i) the high degree of crisis that they expe-
rienced, (ii) the restricted opportunities that they have for
employment. When an individual is afflicted by disability
(Chapter 3 : Table 12, 14 and 15) he is forced to change his
job due to his functional inability. But in the case of the
war-disabled they are forced to take permanent retirement. As
a result both the groups with these limitations have limited
opportunities for social contacts. Conceptually, the social
person prizes the company of other persons as ends and the
new forced condition on him limits his participation in social
activities. Thus it seems that the interfacilitative relat-
ionship between the psychological and vocational adjustment
(Roessler and Balton, 1978), is disrupted by disability.

On the whole the dominant theoretical value people revealed higher degree of maladjustment.

4.9 Psychological World of the Disabled ; An Overview

PART ONE.

Crisis Experience

The disabled persons described their crisis experiemce (Table 1 and 2) as an event in which their normal coping abilities were inadequate to meet the demands of the situation. The disabled person wants to perceive himself as a normal person. Psychologically he has a 'normal' life space (Figure 2). But the disability creates a barrier. He feels cut off from everything that he values in life (Chapter 3 ; Table 3,5, 4 and 7). The barrier is perceived as non-permeable and the disabled person may experience threat to the existing struct- ure in his life space. In this psychological situation, the person perceives his disability as a major barrier (Chapter 3; Table 1 and 2) blocking his path to the goals that he had valued (Figure 3). A person with a disability tends to feel his loss in terms of personal and social achievement (Chapter 3 ; Table 9). Eventually he acknowledges that he is sick, but hopes that he will soon recover. He feels that he must recover first before he can strive for his life goals (Figure 4). The greater degree of crisis experience in the disabled persons could be because of their tendency to compare their

Normal Life Space
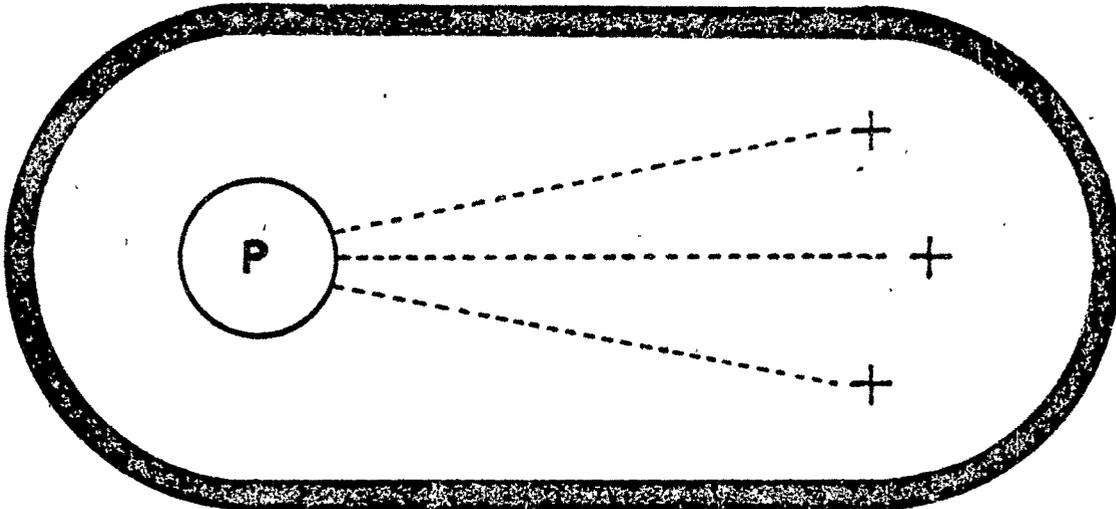
Figure 2 :   P   :   The person, with his needs and
                     abilities.

             +   :   Positive goals or activities which
                     the person values. For example being.
                     independent, earning a living.

            --   :   Path to goal. (adapted from Karr 1977).

Life Space of the Disabled with Barrier
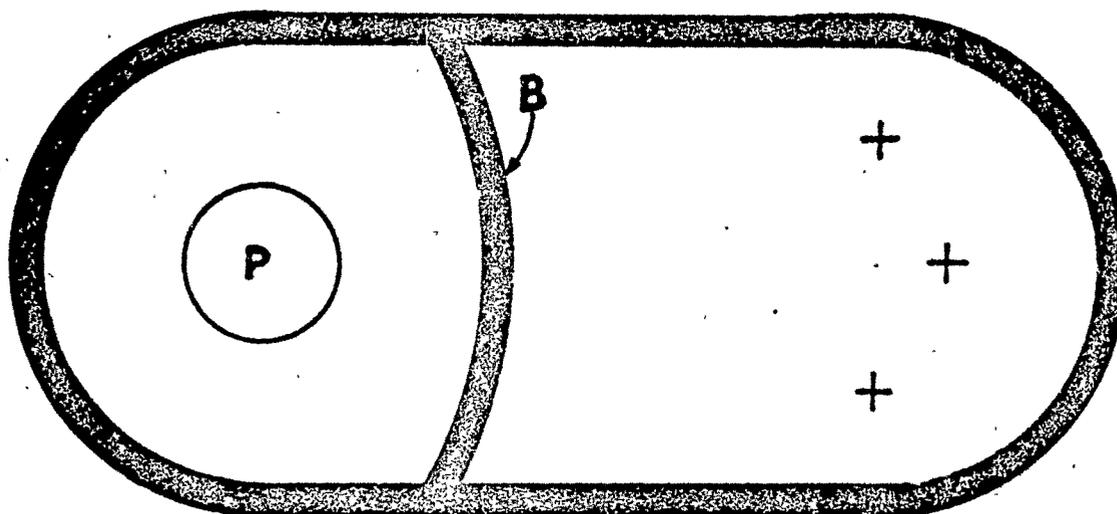
Figure 3. B : The barrier is perceived as nonpermeable,
and therefore nothing can be attained that
is valued (adapted from Kerr 1977).

Life space of the Disabled and the Need of Recovery
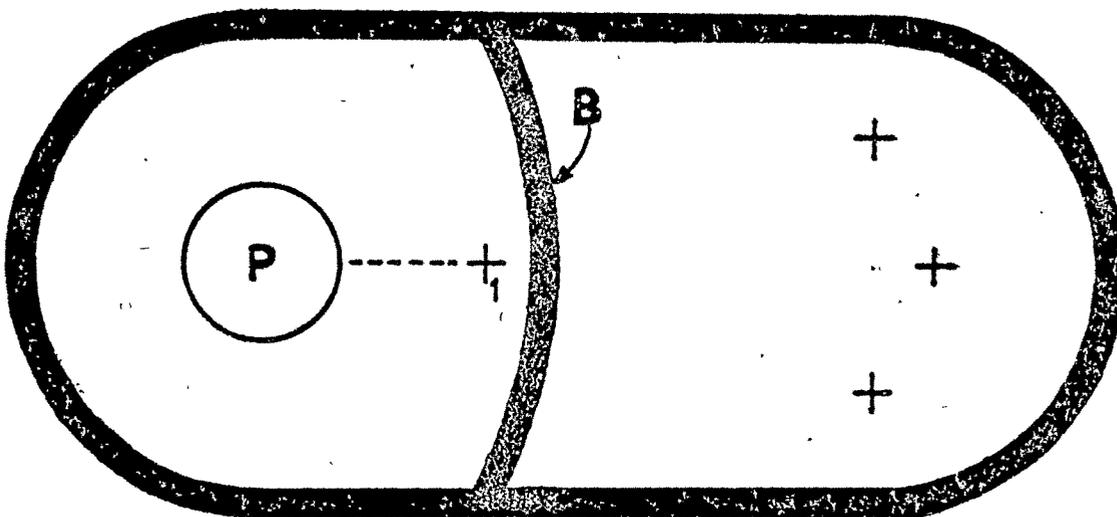
Figure 4.   B.   :   The barrier of disability, blocking
                    the path to the goals the person
                    had valued.

          +,   :   Recovery, which the person feels ha
                    must attain before other goals are
                    accessible (adapted from Kerr 1977).

present condition with the past. This perception of their
own selves further gives rise to the feelings of incomple-
teness and uncertainty about life and thus the greater crisis
experience has been revealed in the interviews by many of
the disabled persons

PART TWO

The disabled person lives in two psychological worlds.
Like everyone else, he lives in the world of the non-dis-
abled majority. He also lives in the special psychological
world that his disability creates for him. These worlds over-
lap, as shown in Figure 6.

Many activities are common to both worlds, but some
activities are engaged in primarily by disabled persons.
Whereas other activities are open only to the physically
normal. The world of the physically normal is larger in the
sense that it contains relatively more behaviour possibili-
ties and is amendable to greater differentiation. This
dichotomy is not unique to disability, however, it can also
be applied to any of the ways in which individuals differ.
For example there is a psychological world of women and a
psychological world of men; a world of the poor and a world
of the rich. Each of these roles, in some degree, requires
different behaviour than the others; but in general they are
compatible with each other. The person is able to play the

role that is required by the different constellations of psychological and social forces that act upon him.

Overlapping Role Situations in Disability

Individuals who have physical disabilities also have other roles. They also encounter their fair share of overlaping compatible, overlaping interfering, and overlaping antagonistic roles. They are almost unique however, in being exposed more frequently, sometimes for a lifetime, to overlaping excluding roles. If this is true, it is not surprising that according to the available evidence and also as seen from the findings the disabled persons with leg and arm amputations (Chapter 3 : Table 11, 12, 14 and 15) and the war-disabled persons tend to be maladjusted (Chapter 3 : Table 17 to 21) more frequently than the disabled-civilians. The excluding overlap occurs between the role of the disabled person and the role of the physically normal person. The dynamics of the situation are shown in Figure 7. It will be seen that the psychological forces acting upon the person in the direction of the world of the physically normal are greater than the vectors toward the world of the physically handicapped (Meyerson, 1971).

The world of the physically normal is larger and better structured with desirable behavioural possibilities. The world of the physically handicapped is relatively underprivileged.

The elogans prevalent in rehabilitation (Meyerson,1971)
that the goal of the handicapped is to *be normal', 'achieve
normality', 'become as normal as possible', 'do the same
things as the non-disabled do', reflect the reality of
underlying psychological and social forces. However, the role
of the disabled person excludes the role of the non-disabled
person in every situation where the disability makes a
difference. The disabled person is separated from some desi-
rable normal goals by a strong barrier. This barrier is
constructed of ability limitations and social limitation',
and both are relatively impermeable. It is dynamically clear,
therefore, that disabled persons are often placed in a position
where they are impelled to strive for relatively inaccessible
or unattainable goals. When the barrier is impermeable (See
Figure 3) and the goal unattainable the behaviour predicted
for overlapping excluding role's will occur.

Varieties of Adjustment Patterns of the
Disabled Persons.

Adjustment Pattern 1.

Figure 5a shows a type of adjustment pattern that is
selected by many persons who have physical disabilities.
These individuals withdraw to the relatively small, restri-
cted life space (Table 63). Their major goals and aspirations
are confined to situations in which they can function at

equal advantage with the normal individuals. The amount of overlap or commonality of the war-disabled with the life space of the disabled-civilians is slight. The valence of the overlap is simultaneously positive and negative. It is positive because some areas, like earning a living, cannot often be restricted to the psychological world of the disabled persons. It is negative because a situation open equally to the disabled-civilians and war-disabled individuals often requires the war-disabled to function at a disadvantage. For example, the war-disabled (Table 16) person applying for a job is not certain whether he will be evaluated negatively as a disabled individual or positively as a person who has the necessary skills for the position. Because of the restricted set-up and the limited skills he is often less able to present himself in a desirable way.

Adjustment Pattern 2

Figure 5b shows the life space of persons who rejected the world of disability and aspire to the world of the normal living. Both the disabled-civilians and the war-disabled desire to do exactly the same things as the persons without disabilities can do. But it is not always certain that the gains achieved are in proportion to the amount of effort that has been required to attain them. For others who are less able or in less favourable social situations the barriers are never breached (Chapter 3 : Table 17 to 21,66, 70, 72 , 73)

ADJUSTMENT PATTERN 2
(b)

World of the   World of the
War-Disabled   Disabled-Civilians

Fi,b   Force in World of the disabled toward
        world of normal living.

Fi-i   Force in World of the disabled condition
        away from disability condition.

Fb,i   Force in barrier toward World of
        disability condition.

Fb-b   Force in barrier region away from
        barrier region.

(Adapted from Meyerson,1971)

ADJUSTMENT PATTERN 1
(a)
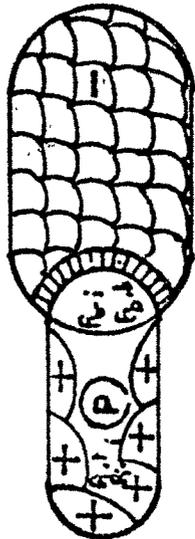
World of the   World of the
War-Disabled   Disabled-Civilians

ADJUSTMENT PATTERN 3
(c)

World of the   World of the
War-Disabled   Disabled-Civilians

Figure 5 : Varieties of Adjustment Patterns.

Psychological World of the Disabled

PSYCHOLOGICAL WORLD OF THE DISABLED

PSYCHOLOGICAL WORLD OF THE NONDISABLED
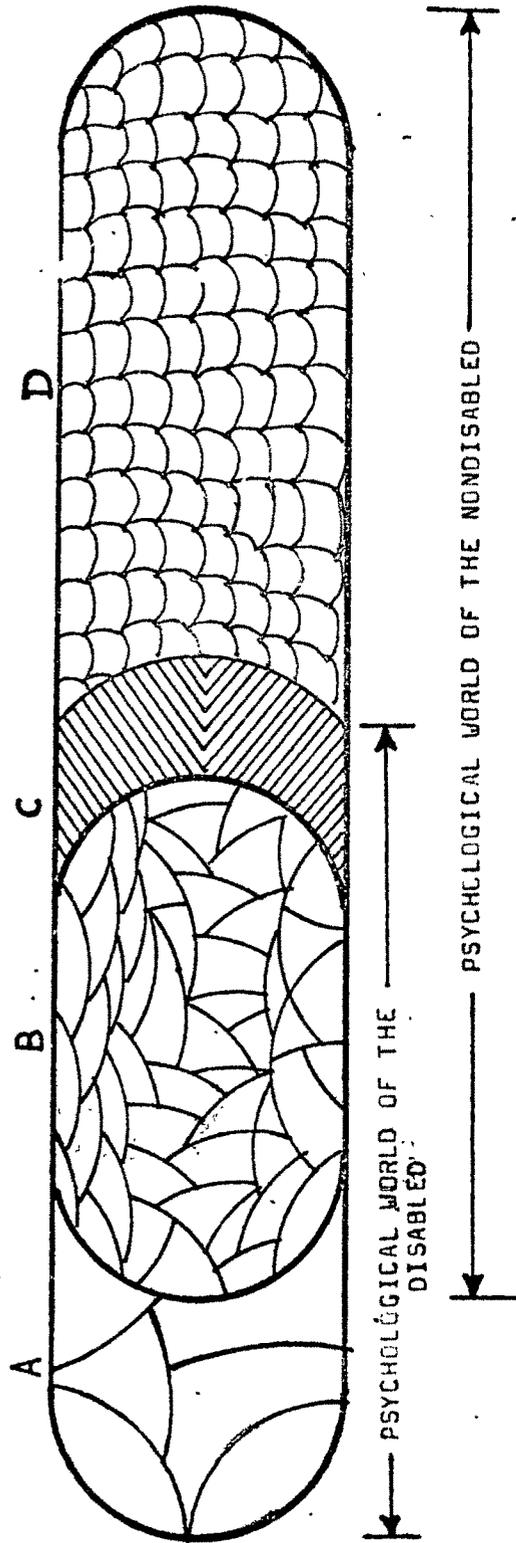
A   Small and relatively undifferentiated are open only
     to the disabled

B   Areas open to disabled and nondisabled

C   Barrier region preventing locomotion of disabled
     person to region D

D   Large, and well-differentiated region open to the
     nondisabled

(Adapted from Meyerson, 1971)

Figure 6 : Psychological World of the
              Disabled

A

B

X_1 X_2

P

$f_{x,a}$
f_{x-x}

$f_{a,b}$
f_{a-a}
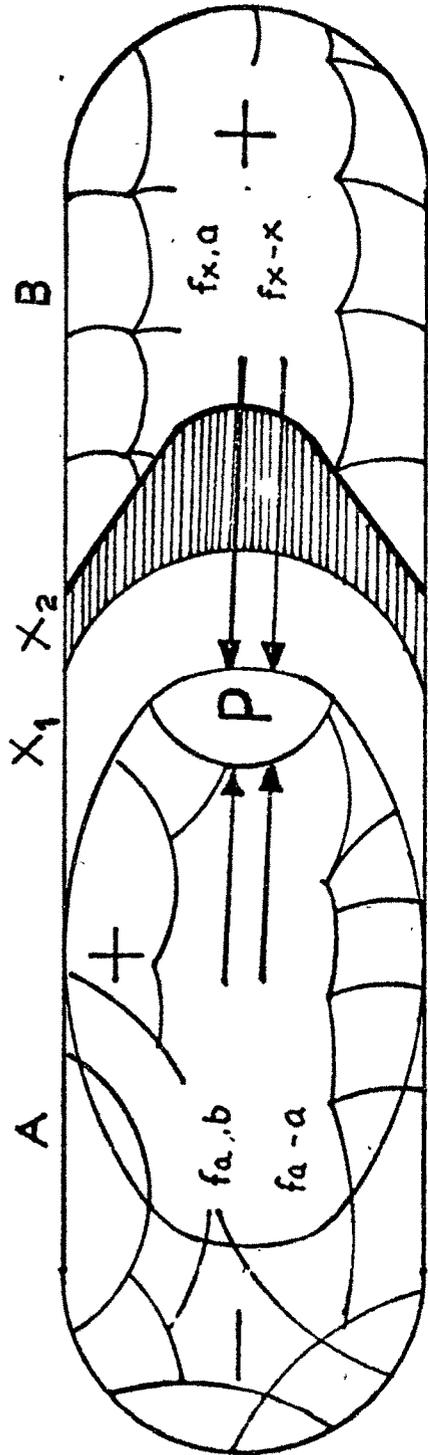
A Situation of the disabled person

B Situation of the nondisabled person

X_1 Ability barrier

X_2 Social barrier

$f_{a,b}$ Force in A toward B

f_{a-a} Force in A away from A

$f_{x,a}$ Force in X toward A

f_{x-x} Force in X away from X

(Adapted from Meyerson,1971)

Figure 7 : Overlapping Role Situations in Disability

even after a lifetime of intensive effort and years of
insecurity and anxiety.

Adjustment Pattern 3

Figure 5 c The schematic representation of the life
space of a person who eagerly enters and values the large
area of commonality that exists between the war-disabled and
the disabled civilians and also between those who have body
impairments i.e. leg and arm (Chapter 3 ; Table 10 to 15) such
a person tends to perceive himself as one who shares many
behavioural areas with others. Impairment is perceived only
as one of his characteristics. For example the disabled person
may be a professional printer an amateur, photographer and a
musician. His disability does not necessarily have a central
position in these above stated activities. The person may feel
as able to participate in them as the persons without disabi-
lities. The special activities in the psychological world of
the physically disabled are considered as additional regions
for rich and fruitful living.

There could be numerous other arrangements of common-
ality, barriers and valences. The three that have been
presented, however, may be considered examples of some of the
major types. Which adjustment pattern is best ? This is a
question that cannot be answered by scientific psychology as
it stands today. The solution must be approached through a

philosophy of rehabilitation counselling (Meyerson, 1971)

PART THREE

REHABILITATION OF THE PHYSICALLY DISABLED PEOPLE

4.10 The Need for Rehabilitation of the Physically
Disabled People.

The individuals afflicted with any kind of impairment
or disability, often feel encapsulated by their disability.
The interview with the disabled individuals conducted in
connection with the present investigation revealed high degree
prevelence of such feelings. The results were also indicative
of their disability problems in different areas of life.

How people with disabilities feel about themselves
and what can be done in order to help them develop a positive
self-image, are considered an important phase of rehabilita-
tion. The physically disabled individual who thinks of himself
as 'incomplete' is not able to function adequately both at
personal and interpersonal levels. Thus, there is a strong
need for adequate rehabilitative support to make the disabled
persons overcome their disability-induced problems of
adjustment.

The General Assembly of the United Nations proclaimed 1981 as the International Year of the Disabled Persons in their Resolution No.31/123 dated December 16, 1976. All the objective -s set forth in the Resolution[*] call for proper psychological understanding of the disabled in his life-setting. The theme of the year : "Full Participation and Equality", itself expresses succinctly the ways and means of achieving these goals.

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* (i)   Helping disabled persons in their physical and psychological adjustment to society.

  (ii)   Promoting all national and international efforts to provide disabled persons with proper assistance, training, care amd guidamce, to make available opportunities for suitable work and to ensure their full integration in society.

 (iii)   Encouraging study and research projects designed to facilitate the practical participation of disabled persons in daily life, for example, by improving their access to public building and transportation systems.

  (iv)   Educating and informing the public of the rights of disabled persons to participate in and contribute to various aspects of economic, social and political life.

  (v)   Promoting effective measures for prevention of disability and for rehabilitation of disabled persons.

4.11 The Goal of Rehabilitation

The main task of the person who is helping the disabled individual is to rehabilitate the "whole man". Much of the problem would be solved by instilling in the disabled person enough-confidence and a sense of worth. For example, one has to help them realize their own personal value which will help them in overcoming critical periods in their lives. Dembo (1959) pointed out that if the self concept of the physically disabled is one of an "incomplete persons", he will further suffer whenever he is made aware of some of his short-comings. Thus, rehabilitation should be aimed primarily at strengthening and reinforcing the positive feelings and self-esteem of the disabled.

Rehabilitation process should also focus on the restoration of physically disabled persons to their fullest physical, mental and social capabilities. It may happen that for some disabled individuals, complete restoration is not possible. Such persons can be helped in achieving the goals which are within their reach according to their optimum ability.

The rehabilitation worker should always keep in mind that to rehabilitate the disabled individual is not an easy task and also that it is not something that the disabled

person can be provided with a 'package' of help and care. The rehabilitation worker should be convinced that what he does for the disabled individual is appropriate and useful ways for him. Here the task for both the disabled individual as well as the rehabilitation worker is one that is unpleasant, difficult, effortful and painful and these efforts may not be crowned always with success.

The rehabilitation worker should try to have frequent meetings i.e. face to face communications with the physically disabled persons. This will help them in gaining insight into the real problems of the disabled. In other words, the rehabilitation efforts ought to be client-centered. The rehabilitation worker should try to know what the disabled individual is capable of doing and train him in that specific direction. He can also be helped to find a suitable job according to his ability and within the available resources.

Medical rehabilitation researches have shown that considerable changes occur not only in the external living conditions of the disabled person (e.g. changes in occupational situation, role changes, emotional changes, the use of technical aids etc.), but also in the physical sphere (e.g. psychic assimilation mechanisms such as reactive depression, repudiation on the part of the disabled persons and members of the family). The medical rehabilitation

distinguishes between two types of influencing factors in
the adjustment process.

1.   Internal influencing factors - those which are inherent
        in the patient himself (type and extent of handicap;
        pre-morbid personality; psychic reaction to disease/
        handicap etc.).

2.   External influencing factors - those which are found
        outside and around the disabled person (the family of
        the handicapped person and its reaction to the handicap,
        the role of the fellow disabled persons, variables
        pertaining to the rehabilitation facility such as the
        rehabilitation objectives pursued, the rehabilitation
        programme, the staff with its formal and informal
        functions).

        With the knowledge of these influencing factors, the
rehabilitation worker can understand with little effort the
complicated process of adjustment and can try_to_achieve maximum
possible rehabilitation (physical, psychic, social, emotional
and occupational).

4.11 (a) Physical Restoration:

        Physical restoration will help in modifying the patient's
self-image as a "shattered body" and will help him meet personal
and vocational goals. The integrity of the soma concerns some

disabled persons (amputees) and they will oppose the
surgeon's recommendation of shortening an overlong stump
so as to facilitate subsequent prosthetic restoration (Neff
and Weiss 1965). Physical restoration could be achieved
with the help of the artificial limbs. This would make easier
the complicated task of the rehabilitation process. Rehabi-
litation workers have come to realize the truth about the
maxim: "Never train around a disability that can be correct-
ed or reduced". It means that every medical, surgical and
auxiliary service should be used to remove or reduce a dis-
ability to the minimum before providing any rehabilitation
training. Physical restoration may in itself be vocational
rehabilitation. Physical restoration means "the system of
treatment that employs every device and measure to expedite
recovery, shorten the period of convalescence and secure for
the patient the maximum development of his physical and mental
capacities (Bhatt 1963). One amputee said : "I told the
surgeon I want to hold on to as much of myself as I can". The
attempts to maintain physical integrity at the expense of
improved function are the reactions to the cineplasty proce-
dures.

4.11 (b) Psychological Restoration:

    The need for physical restitution often spills over
into psychological areas. Most of the amputees show a need
to incorporate and assimilate a prosthetic device into their

body scheme. It is very common to hear an amputee state
explicitly that he regards his artificial limb as "my leg".
In making use of the artificial limb numerous other examples
also shed light on the subjective, psychological factors that
influence the rehabilitation process. It had been conjectured
(Weiss, 1958) that the mechanically sophisticated and complex
prosthes has some of the complexity of a natural limb, which
could be integrated more readily into the established body-
concept of an amputee than a relatively simple and convent-
ional wooden or plastic limb. The hydraulic mechanism
"substitutes" for the last muscles and facilitates a more
natural gait and also, at the same time, requiring less effort
and energy on the part of the subject than is the case with a
conventional prosthesis.

4.12 Rehabilitation for Work

Rehabilitation programs should aim at training the
persons for remunerative employment and to restore the disabled
individuals to a level of self-sufficiency which is deemed
essential to the well-being of the society. Secondly, it should
aim at achieving the total development of the disabled person:
physical, psychological, social, emotional, vocational and
recreational. It must have its roots in utility and economic
feasibility. The rehabilitation must ensure and enable the
disabled individual to fulfil his personal potential and
enrich his life, private as well as communal, and prepare him

for active, independent and responsible existence as an
integral part of his family, his occupational group and
above all his community.

Regarding the issue of "Independence of the Disabled"
the disabled individual should be encouraged to "live
independently", feasible within his disability limits. He
should be encouraged to make use of the prosthesis to gain
maximal independent living. "Independent Living" means a life
which is productive, purposeful, meaningful and socially
useful and satisfying.

4.13 Need for Co-Ordinating Rehabilitation Services

The complex task of providing rehabilitation services
to the disabled individuals has become much appreciated in
the recent years. Yet adequate linkage have not become esta-
blished between the numerous agencies involved in the process.
Manpower planning for the needs of the disabled are still
non-existent.

The desired expansion for aids and adaptation continues
to be slow not because of inadequate funds but because of
insufficient organisational integration between occupational
therapy assessment and community nursing services.

There is no clear authority to draw together the components of the multi-disciplinary team involving mobility, finance, counselling, engineering, family support, employment, training, resettlement and clinical care. There is a great need for rehabilitation teams in every town and city.

4.14 Goals, Objectives and Action Plan for Rehabilitation in the Indian Context:

First the workers involved in rehabilitating the disabled persons must understand that rehabilitation is a single continuous process, beginning with the onset of injury and continuing throughout the treatment untill final resettlement is achieved.

The disabled person has a right to expect a comprehensive and coherent services to meet his needs when he requires assistance from others, but this is often lacking. At present no one person in the National Health Service of Social Services is responsible for co-ordinating all the facilities and services available.

The major issue concerning the rehabilitation of the physically disabled needs a closer attention of the local authorities, National Health Services and Voluntary Organizations who provide services and facilities, to the disabled and of those who are concerned (particularly clinicians) the co-ordination and integration of these services.

The Ministry of Social Welfare, Govt. of India (1980) has set-forth the following major objectives for the rehabilitation of the disabled people:

(i)   To evolve a National Policy on the disabled to include educational training, employment, measures to achieve full social integration and protections and guarantees under the law.

(ii)   To initiate a few practical programmes that would carry immediate and significant benefits to handicapped people themselves.

(iii) To initiate concrete programmes aimed at bringing about the utilization in every way possible, the integration of handicapped people into the community. Currently, there is a strong tendency to institutionalize handicapped people. This tends to inculcate among the handicapped people a sense of dependence which prevents them from fully participating in community life even after they leave protective walls of institutions. It also tends to create a certain amount of aggression leading to maladjustment at work and in other social settings.

(iv)   To develop a strong national disability prevention
       programme, currently, only a National Programme for
       the prevention of Blindness is in operation.

(v)   To prepare a base for research and development
       through the National Institutes, Institutes of Techno-
       logy and other bodies so that in the years to come
       programmes for rehabilitation of the handicapped should
       be responsitve to changes in the social or economic
       climate and to developments of techniques and techno-
       logies in the various disciplines bearing on this field.

(vi)   To develop and initiate a planned network of informations
       and publicity services for dissemination of information
       on new techniques, equipment programmes for the handi-
       capped for employers, teachers and social workers. The
       services should not only disseminate information but
       stimulate a greater awareness among opinion groups of
       the employment potential of the handicapped.

A. Suggested Action Plan :

       It would be desirable to start with as broad a base
as possible. For achieving the desired goals the following
ways are suggested:

(i)   To put forward some schemes for encouraging integra-
       tion of the disabled persons.

(ii)   To establish a good number of rehabilitation centres in each city and State to carry out differential diagnosis of disabilities and offer advice if required or whenever necessary.

(iii)   To undertake programmes for the training of the physically disabled with a view to improving their standards of living or helping them to attain a good fruitful and purposeful living.

Employment :

Another very important issue that requires immediate attention of the rehabilitation authorities is employment: The disabled persons can be helped by :

(i)   Keeping in reserve few vacancies for the disabled in all sectors of economy (public or private).

(ii)   Providing aids and equipments needed by the disabled.

(iii)   Guaranting a good number of concessions to the disabled person for example conveyance allowance, escort allowance if required and the like.

(iv)   Establishing sheltered workshops and employing various categories of the handicapped persons, providing financial assistance to organizations which undertake to set up such type of workshops and to set up model workshop in each State if possible.

(v)   Encouraging and stimulating the establishment of
        cooperatives run by the disabled persons themselves.

(vi)   Providing loans at preferential rates of interest
        and some special concessions to the childrens of
        war disabled. As with their limited income they face
        ample problems, hence there is a need to study their
        conditions more seriously and provide them the
        necessary help.

Mental Health Services :

(i)   With a view to preventing emotional disturbances and
        social isolation a programme of mental health for the
        disabled must be initiated.

(ii)   Various ways of overcoming the disability-induced
        problems should be rigorously studied and the results
        should be put to practice.

Vocational Training :

        Vocational training also could be of a great help to
the physically disabled persons. In this regard the first
and foremost need is to reserve some number of vacancies in
all the State and Government run institutions. In each
institution arrangements for the special instructions should
be made as per the needs of the disabled persons.

Education and Training:

It should be the responsibility of the N. S. S. (National Service Scheme) to create awareness in the disabled persons about the already existing services. This could be done with the help of the mass media communication and by disseminating the available information by publishing special pamphlets from time to time.

Rewards and Encouragement to the Disabled Persons:

A scheme to give awards and provide special facilities to the war-disabled, who have sacrificed their limbs for the cause of the nation should be evolved. They should be given their fair-share and also the works of those who have distinguished themselves in the various fields of life should be acknowledged. The necessary attention should be paid on widening the occupational choices more for the war-disabled persons because they have very limited means of earning.

In General :

(i)   In keeping with the already existing National programme set forth by the Ministry of Social Welfare, Government of India, special ways and means should be adopted for helping the disabled persons.

(ii)   Special technical institutions should be established to impart training to the disabled persons.

(iii)   Some indepth studies on the cause, consequences
        and the prevalence of various disabilities should
        be encouraged.

(iv)   Special attention should be paid in designing the
        artificial limbs and wheel-chairs with the help of
        the latest technologies developed in this area.

In any program for rehabilitation of the physically
disabled, specially in Indian Context, the major objectives
could be achieved by bringing in harmony and restoration of
the integrity of the self-image, concomitant with a respect
for oneself as a person, despite physical limitations. In any
attempt at preventing disability or rehabilitating the dis-
abled people, it may be said that those who are engaged in
such tasks should try to see the problems of the disabled from
the angle of the disabled i.e. have an 'insider's view' which
is a form of a 'felt-knowledge', 'empathy' rather than sympathy
is the word. The disabled must be understood and approached
not only in terms of his general personality dispositions but
rather in terms of his disability-induced special assets,
and above all, in terms of his attitude toward life. Help
when offered indiscriminately, i.e. help that is offered
unwanted and the help that is offered by one who does not
know 'how to' and 'when to' offer help, often damages the very
core and purpose of help (Gon et al, 1981).

Hence, an adequate understanding of the psycho-social aspects of physical disability must precede all preventative, curative and particularly the third-phase of medicine — the rehabilitation of the disabled.

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