

THE COMPLEXION OF MISFORTUNE:

Psychological Observations on the Meaning of Loss to the Disabled*

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I would like to talk with you about misfortune, a word that we know covers a lot of ground. All of us here deal with persons who are on the receiving end of misfortune. We make an attempt through our sciences and our arts to help these people overcome their misfortunes. One of the purposes of your conference is to help perfect your techniques and clinical know-how so that you better serve these people.

For the moment let us define misfortune as a permanent loss of natural body function or body part. *The patient impresses upon us the fact that his physical loss is only the beginning of his misfortune.* Instead of dwelling at length on the many facets of loss, let us run through the list quickly. Let us take a patient, such as an amputee, who has told us about his losses in no uncertain terms. Physical loss has been mentioned. We also hear of the patient's loss in esthetic appearance to himself and others—the loss of work, income, and the prestige that is involved in working, or the loss in one's capacity to do as good a job of homemaking as before—the loss that he feels in social status—the patient says to himself: "People may think differently of me"—there is his loss in play and recreation. Finally, and probably most important of all, is the fact that the patient thinks and feels differently about himself.

Up to this point we have discussed only some of the ingredients of the patient's misfortune. That may sound strange to you, and perhaps you are thinking, "Haven't you said enough already?" But to complete the picture *we have to consider his life and personality before his disability, his attempts to deal with his misfortune, and, how others around him deal with the patient as a disabled person.* Now our stage is set—our play is only partially written—the prepared part is the patient's pre-injury style of life and set of values which will help determine how he reacts to his disability. The rest of our drama, which proceeds from the time that the person becomes disabled, is still only partly prepared. The rest of the play is mostly an impromptu, ad-libbing type. Why?—because we have to wait and see what happens to our hero or heroine as he or she becomes part of different scenes where people react to the disability, where people act according to their own interests and values; we watch our patient use his resources to handle new problems, new experiences with others and new frustrations.

First, the patient. Before his disability he had a fairly intact body. His estimate of himself always included his body. He may have taken this body for granted, or, he may have prized it or placed considerable importance on it because of the satisfactions and prestige it gave him. This person had a way of life which included friends, work, activities, and, certain feelings and attitudes toward himself. In this pre-injury, pre-handicapped condition he was placed among the non-handicapped. When he looked at a handicapped person with a visible injury, he noticed the difference—more about this later.

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Now that this person is disabled, he still looks at himself the way he looked at disabled people before he became handicapped. He has the same outlook about physical disability that he had when he was a non-handicapped person. Our disabled patient is a house divided. This is a necessary phase of life for every disabled person. Some patients feel this much more keenly than others. This may be called psychological or emotional inertia—we can't shift our point of view, our emotions, in the same way that we turn the ignition on in our car.

Next, we consider the actual emotional reactions to misfortune. Your own experiences with patients and others will support these observations. The most common initial reaction is what I call emotional anesthesia. The person says to himself or others, "This isn't real—I must be mistaken—this couldn't happen to me—it's only a bad dream from which I will awaken." This emotional anesthesia is particularly true in the case of traumatic loss. But it is also relevant where a person has been prepared for his loss by the anticipation of surgery or by the fact that he is aware that there may be after-effects of his disease which is still in its acute phase. This anesthesia is clearly a protective device. You have experienced it in the loss of a loved one, perhaps in the loss of a job, a home. Quickly following this we have the classical period of "mourning the loss," the period in which the person grieves his loss.

From here the patient is on his own, so to speak. He can be angry about many things, some unrelated to his disability—he can withdraw into isolation—by his actions he may be saying, "let's pretend nothing happened, my loss doesn't make any difference to me." He may expect the world to do for him what he could do for himself; he may even demand this from us—he may become confused, bizarre and quite sick emotionally. Some people find it necessary to deny any mourning, any bereavement—perhaps to such a person mourning would mean that he is trying to face his loss and understand what it means to him. Frequently it is reported that a single patient shows most of the above reactions in a short span of time—even in a day. In other words, he may be testing out all of his emotions and is still in a fluid state emotionally. As each patient is observed in his behavior following his loss, we can make some appraisal of the style of life he led before the loss.

Finally, I think *most patients come to a more stable, or at least, more predictable way of dealing with their handicap, and they begin to overcome many of its limitations.* You have to marvel—I marvel—at how a person who seems so depressed, bitter, resentful and upset, can, in say six months or a year, recover much of his old self and life activity, and even feel stronger in handling the usual daily frustrations and obstacles.

At this point I would like to go back to our patient—back further—back to when he was not disabled. I said a little while ago: "When he (the patient) looked at a handicapped person with a visible injury, he noticed the difference." He felt better off—or perhaps pity—or even frank irritation, or perhaps genuine sympathy—sympathy without those subtle overtones of feeling, something that he's supposed to feel. My reason for trying to recapture our patient's pre-handicap attitudes is this: *when he becomes physically disabled, he still retains the values about his body that he had when he was not disabled.*

We are indebted to a group of social psychologists, Dembo, Leviton and Wright, for this emphasis on values. Inevitably, *our patient continues to look at himself with the eyes of his non-handicapped fellow citizens.* He compares his loss with the lack of it among the non-handicapped. In making the com-

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parison he gives himself the short end of the stick. The patient's chain of thinking and feeling is of this order: the absence of my leg is to me the absence of part of me; I am not as good a person without my leg; I'm not as good as that fellow there who has both his legs.

Now if this is a person who had too much good feeling about his body before his disability, he will have greater difficulty shifting his values away from his lost leg. The misfortune here is that he may have had too much of a good thing—the good thing being his excess satisfaction with his body and the excess importance placed on this satisfaction with his body. Everywhere this patient turns, he finds the world of the non-handicapped about him. Our patient feels like he is in the minority because the majority have whole bodies.

The rehabilitation of the complexion I have described is up to the patient and society. When our disabled individual begins to enlarge his scale of values he sees that his emotional estimate of himself can be just as worthwhile without having to include in this estimate the presence of his lost function. It would be an asset to have his lost arm, but, and this is very important, he has other assets, maybe even new ones.

A veteran, wounded in North Africa, really realizes after two years of recuperation and physical rehabilitation, that he could have been killed on that night patrol, that he wasn't and now, two years later, he has a lot to be thankful for: the thought of this occurred to him right after he was wounded but there was a lot of work ahead for him before this thought grew into a lasting feeling that was part of his new scale of values. How did he progress to this point of view? *This is an outlook—a point of view—in which he actually chose to live because at several points in his convalescence he had thought about suicide and finally rejected it.* This man showed such splendid growth because he had people around him who understood his problem—they didn't try to talk him out of his depression, his irritability, his impatience with his prosthesis—at the same time they encouraged him to talk,

to say what was on his mind, to complain, to talk about his hatred for himself and so on. By the way, he met other patients who razzed him out of his lethargy at times. He was mature emotionally before he was wounded. However, he met people after he became disabled, whose scale of values were large enough to help him think of himself as a person. These people he met were generous in the sense that they shifted their own values away from physique to people. At the same time they let this man set the pace. This veteran felt sympathy instead of pity, acceptance instead of tolerance.

Up to now, I have been emphasizing the patient, before and after the onset of his disability. But the complexion of misfortune would not be adequately covered if we did not touch upon the non-disabled. Society represented by you and me, the patient's family, his friends, his co-workers, and the professional workers who serve him—this society plays an important role in the patient's progress through the way that it reacts to the disabled person. The increasing size of your professional organization and mine is one sign of society's greater willingness to work with the disabled individual. *We all share the patient's misfortune.* In a sense we need to enlarge our scale of values just as we hope the patient will enlarge his.

If so much importance was not placed on physical achievement and appearance, the patient's lot would be a little easier. A word of caution here . . . because we may look at a disability and its emotional meaning in a more objective, detached manner we should be careful about imposing our point of view on the patient. We may feel that a disabled patient is as worthwhile a human being disabled or not; that he should place less importance on his loss; look to his other assets and so on. But how can he shift his point of view so easily when all around him he sees the TV ads, the glamour movies and the cult of beauty? He is as susceptible, if not more so, to these values about his body, as the rest of us are. Knowing this, we have a more complete appreciation of what our patient goes through as he feels his loss and its meaning in our society. *If we can communicate to our patient some understanding of what he feels, how he looks at the world, we are closer to him and helping him some.*

Lastly, I am interested in a kind of preventive mental hygiene in which we might try to instill in our children and friends not only the blessings of a healthy body but also the values of friendship and intellect which can rank as high as those of an intact body. So often a person who becomes disabled is catapulted into the position of feeling like a concert violinist who has lost the "pinkie" of his left hand. By *trying to teach others to prepare for misfortune*, be it handicap, death or loss of income, we shift the emphasis in life from external values to a focus on the human person; if we are lucky, we may render a service to them.

READING LIST:

1. "Psychological Aspects of Physical Disability." Office of Vocational Rehabilitation, U. S. Government Printing Office, Washington 25, D. C.
2. "Psychology of Personality," by Ross Stagner, New York: McGraw-Hill.