Psychodynamics of the Young Handicapped Person

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Psychodynamics of personality and ego development are related to motor development. The body image concept, important for normal psychologic performance is often impaired by somatic or cerebral defects. Adolescents are particularly depressed by loss of self-esteem and thwarting of future career goals. Sexuality is an important consideration for the handicapped.

Orandum est ut sit mens sana in corpore sano. Your prayer must be that you may have a sound mind in a sound body. This quotation from the Satires of Juvenal, who lived from 60 A.D. until about 130, epitomizes the philosophy of society in the whole gamut from the most primitive to the most sophisticated contemporary. The former, with pristine pragmatism, evicts the physically handicapped to be eliminated in the wilderness. The latter, with due consideration of national and world affairs, often advisedly assigns economic priorities to more useful projects and segments of the population. The handicapped are, thus, segregated by societal factors as well as by the intrinsic and extrinsic effects of their disabilities.

Disability, Handicap, and Socialization

"The word 'disability'" wrote Mitchell (1), "refers to the interference with function caused by a physical, mental or emotional abnormality. 'Handicap' relates the disability to what is expected or required of the child in his particular environmental circumstances and implies an adverse effect on the quality of his life." Susser and Watson (2) distinguished three components of handicap: organic, functional, and social. The organic component is the actual impairment, the static condition of the disease process. The functional component is the disability, the limitation of function imposed by the impairment and the individual's psychologic reaction to it. The social component is the handicap, the manner and extent to which the other two components limit the performance of social roles and relations with others. It is appropriate to note that not every disability need be a handicap. Psychologic and occasionally social factors may exaggerate a disability, that could be overcome or compensated, into a handicap.

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Behavior is manifest performance in relation to physical or societal surroundings. It consists of an individual’s actions, others’ reactions to his actions and the interaction between him and other persons. In essence, behavior mediates socialization or failure of socialization for the individual.

Kagan (3) described four major mechanisms of socialization that are similar for all cultures, although the content of what is socialized differs across cultures. The mechanisms are desire for reward, fear of punishment, identification, and imitation. Each is strongest at different periods of development. The acquisition or suppression of concepts of value is likely to result from the desire for identification with someone loved, respected, and admired. These mechanisms apply to the handicapped as well as to normal children and youths, for even the moderately retarded handicapped individual has a human behavior pattern and a personality.

Effects on Behavior

There is widespread agreement among professionals who work with handicapped children and youths that behavioral disturbances in this group result mainly from environmental and emotional factors. Freeman (4), describing psychiatric problems in adolescents with cerebral palsy, was of the opinion that temper outbursts, hyperactivity, so-called “catastrophic reactions,” and other emotional aberrations often attributed to brain damage may be largely due to overprotection, lack of confrontation with the usual consequences of behavior, imposition of painful physical procedures, or excessive or unreasonable environmental pressures. Howell (5) declared that most behavioral disturbances appear to be caused primarily by external influences rather than by the handicap itself.

In view of these opinions it is interesting to consider the conclusions of Graham and Rutter (6) who studied the total population of 11,865 school-age children on the Isle of Wight. These investigators found the rate of psychiatric disorders in the general population of children ten to eleven years of age to be 6.8%. These disorders were nearly twice as common, 11.5%, among children with chronic physical pathology not involving the brain. There were no differences in the rate of psychiatric disorders in relation to the diagnoses of the physical conditions. Over one-third, 34.3%, of children with neuroepileptic conditions showed psychiatric disorders, five times as many as in the general population and three times as many as children with physical disorders not involving the brain. The authors were of the opinion that the high rate of psychiatric aberrations in the neuroepileptic children was due to the presence of organic brain dysfunction rather than just to the existence of a physical handicap, although the latter usually contributed. Graham and Rutter concluded that, although behavioral and emotional disorders are common in children with organic brain dysfunction,
especially in cerebral palsy and epilepsy, there is no specific behavior syndrome for children with cerebral damage.

In a conceptualization reminiscent of Watson's theory of behaviorism, Bowlby (7) stated that emotion is a phase of an appraisal process and not the cause of behavior. It is experienced only after behavior has begun as a result of feedback from the voluntary muscles and the viscera. Although this observation was written relevant to normal children, it may well contribute to the understanding of the behavior of the physically handicapped in whom peripheral feedback may be distorted or absent.

The behavior of the handicapped may be considered to be a function of a combination, or better, of an interaction of physical and cerebral disabilities with personal and societal reactions to these. The nature of the disability does not mediate a particular type of personality for the afflicted. There is no paradigm of emotionality for the handicapped.

**Psychodynamics of Personality Development**

The psychodynamics of personality development are closely related to and strongly influenced by motor development. The child's proper orientation in time and space, his appreciation of his physical ambience, and his equilibrium, posture, and ability to maintain a stance against gravity are all dependent upon his neuromuscular development. The personality and behavior of the child who is afflicted with a neuromuscular disorder from birth may differ greatly from that of a normal child. The lack of stimulus input due to his physical limitations, his own frustrations and the attitudes of others toward him will all affect his psychosocial development in varying degrees. Perceptual deficits, so common in cataclysmic central nervous system disorders like cerebral palsy, will further influence an individual's ability to function in a culture so oriented toward cognitive capabilities for learning, for social awareness, and for employment.

Most other mammals are motorically more mature than the human at birth. They can stand and walk with increasing proficiency very soon. Yet, their physical attachment to the mother is prolonged and they follow her closely for as long as one to two years in the larger species. On the contrary, the normal human infant, so physically limited for many months, separates himself from his mother at the first moment any mode of locomotion is possible. Rheingold and Eckerman (8), in their studies on young infants, noted that the separation, once effected, increases in distance and duration over the life of the individual. These authors did not propose that the infant's physical detachment from his mother is a negation of emotional attachment to her.

During the early formative years, the normal child achieves increasing physical independence as the maturation of his central and peripheral ner-
vous system affords him proper coordination and equilibrium and the ability to ambulate, to explore, and to learn. This physical maturation is accompanied by the emergence of speech, language, and communication so necessary for social adjustment. The individual's somatic and cognitive development is paralleled by his ego development. The nature and extent of the former will have a profound influence on the latter.

The phylogenetic reflexes with which evolution has endowed the human neonate have psychoanalytic significance. These reflexes, so essential for the physical survival of lower mammals, are ontogenetically important in the emotional development of the human infant. The tonic neck reflex is the first motor pattern to appear in the fetal infant. It is well developed at birth but would not protect and right a falling human infant as it would an arboreal animal. Hence, his dependence on the mother for holding him up against gravity. The grasp reflex that enables the young ape to cling to its mother allows the human infant also to maintain contact with the mother's body for warmth and nursing. The rooting and suck reflexes are related to the grasp reflex. These reflexes are very important in promoting the early libidinal gratification of the individual. As the maturation of the brain and nerve tracts proceeds to the point of independent physical functioning, the normal child gradually renounces his need for maternal physical contact and ego development proceeds apace.

The child who had prenatal or perinatal brain damage will suffer abnormal motor development, varying according to the area and extent of damage. His primitive reflexes may persist beyond the time when they would normally disappear. The resulting different neuromuscular defects may have varying psychologic effects on personality development. Cerebellar lesions cause asynergia and balance difficulties along with prolongation of primitive postural and righting reflexes all of which interfere with locomotion. Children so affected may manifest emotional as well as physical clinging. They form deep attachments and feel markedly insecure when left alone. Children with basal ganglion (mainly striopallidal) and extrapyramidal pathology exhibit choreoathetosis and are overresponsive to stimuli. They are constantly struggling to control their involuntary gross movements and to avoid stimuli from other persons. Consequently, they often seem to be negativistic and resistive. Under adverse circumstances, their interpersonal relationships may, therefore, deteriorate. Children with spastic limbs as a result of pyramidal tract lesions can learn to use residual functions, and can often ambulate and maintain their balance with or without braces and crutches. These children tend to be less clinging than cerebellar ataxics and less resistive than athetoids.

Muscular dystrophy is an example of a disease whose handicaps affect a child after neuromuscular functions have completely matured. The
pathology is in the skeletal muscles and leaves the brain and nervous system intact. Until muscle weakness becomes severe enough to limit movements, there is no loss of balance or posture. There are no involuntary movements present. The dystrophic child, therefore, although physically dependent, is not psychologically dependent. He is usually content to be overindulged by those around him.

**Body Image Concept**

An important difference between the ideation of the child with disabilities that are present at birth and that are most often due to brain damage, and of the child disabled by later disease, is the body image concept. Paul Schilder defined the human body image as a gestalt picture of one's own body formed in one's own mind as a result of the synthesis of and interpretation of experiences and perceptions. Impairment of somatic functions and actual distortion of peripheral body structures alter the conceptualization of one's own body image. The child with abnormalities that occurred during gestation, birth, or early infancy has a (potentially) distorted body image from the outset. The individual damaged later by disease or accident has another kind of psychologic problem. He will be conflicted over the discrepancy that exists between his established body image and the altered reality. This fact can produce a severe anxiety state.

**Speech and Language**

As important as physical capabilities are for personal independence of action, so speech and language are for communicating one's needs and desires and for social interaction. In neuromuscular diseases with accompanying cerebral pathology, speech is often affected by central or peripheral defects, or both. Brain damage may produce sensory or motor aphasias and perceptual deficits that affect incoming or outgoing transmissions. Peripheral involvement of the muscles of the mouth, tongue, larynx, chest, and diaphragm can produce dysarthria by affecting phrasing, phonation, modulation, and respiration. These defects are seen mainly in the spastic and athetoid cerebral palsied. The frustration of being unable to communicate adequately can aggravate the already present discouragement resulting from physical disability.

**Ego Development and Realistic Confrontation**

Ego development actually starts in early infancy. To arrive at a normal healthy ego, the child must experience suitable gratifications for the usual frustrations such as hunger, cold, pain, fright, and so forth. There must be adequate sensory stimulus input from the physical and human environment. The child must have a sound mind in a sound body to conceptualize a
normal body image. Finally, there should be emotional satisfaction in the
proper personal interaction with parents and other persons.

In the child defective from birth, and especially if there is concomitant
brain damage, even id drives may be stultified and thwarted. If sensory
afferent, perceptual, and motor efferent functions are imperfect, peripheral
feedback is impaired and the child may be underreactive or overreactive
to simple internal or external stimuli. His primitive needs may be poorly
discernible to him, let alone to the parent or other person caring for him.
Certainly the ego is very likely to be affected by frustrations unable to be
gratified, by lack of proper stimulus input and by the child's own attitudes
along with those of others with respect to his disabilities. Retarded ego de-
velopment usually results in an immature, insecure person.

The psychologic reactions of a child to a disabling disease differ from
those of an adolescent. The child's main attention focuses on the physical
aspects of his disease; pain, if this is present, and loss or absence of function.
Secondarily, he reacts to negative attitudes of others. If he is hospitalized
or is placed in a long-range institution, he may suffer from separation from
his family or even from isolation. An older child at the stage of develop-
ment of a superego may develop strong feelings of guilt. These may result
from fantasies about losing function of limbs because of going places or
doing things against parental restrictions. They may also be related to
fantasies of punishment for death wishes in ambivalent feelings against
parents. On the other hand, if the handicapped child is sheltered or has
adequate nurturing and kind handling, he might be quite happy. Essenti-
ally, he is oblivious to the future and may be quite unrealistic in his plans
for the future. Many severely physically handicapped children, when quered
about their career ambitions, will answer that they will be doctors,
nurses, policemen, train engineers, or pursue other occupations improbable
for them. The child handicapped from birth may, in a sense, be better ad-
justed than one who becomes disabled after having achieved physical
competence. The former never had normalcy whereas the latter is aware
of losing something valuable.

The adolescent is no longer a child nor yet an adult. He is at a cross-
roads, leaving the shelter and absolutes of childhood and approaching
the responsibilities and accountabilities of adulthood. Becoming more
cognizant of the handicap of a long-standing chronic or neonatal disease,
the youth despair of his future. The depression and anxiety are usually
more sudden and severe in the presence of a new acute disabling illness or
injury. The nature of the illness, among other factors, influences the
way a youth reacts to it and the extent of that reaction. The knowledge
of the new affliction as to the diagnosis, the acuteness or chronicity, and the
prognosis will affect the youth's attitude. The type of defect—neuro-
muscular, sensory, perceptual, aphasic, or dysarthric matters greatly. The functional impairment: spasticity, athetosis, ataxia, or the sensory involvement: visual, auditory, kinesthetic, will have significant bearing upon the individual's emotional and social adjustment. In the adolescent age group career ambitions and thoughts of economic self-sufficiency and social independence are high priority items.

If the body image concept is important for the developing ego of the child, it is almost paramount for the ego and self-esteem of the adolescent. At a time when body development, secondary sex characteristics, and physical prowess are so significant for the individual and for his or her peer relations, an existing or new defect can prove to be catastrophic to one's emotional stability. The conflict engendered by the alteration of body image resulting from a physical disability is far more powerful in the adolescent than in the young child.

The superego, having developed more completely in the adolescent, now may harbor more serious guilt feelings, not over fantasied sinning or death wishes but because of the person's awareness of the burden that he and his handicap offer to his family and to society. Some accept dependence more graciously than others. Some strive mightily to overcome the handicap of their disabilities. Some lapse into hopeless despondency.

There is an interesting parallel between the reactions of a person informed of having a fatal disease like leukemia or cancer and a youth stricken with a nonprogressive handicap. The initial reaction is one of disbelief and denial. The doctor is mistaken. This just cannot be happening. The patient is certain that the disease and disability will pass. The second stage of reaction is that of frustration and anger that the condition has actually occurred. This is followed by a reactive depression as the afflicted youth grasps the full impact that the condition will have on his life. Finally, acceptance of the reality will eventually take over with more or less realistic plans for treatment and the future.

Role of Parents

In all of these idiographic considerations of the handicapped individual only casual mention was made so far of the role of parents, a role of tanta- mount, if not paramount, importance. A child's deformity or disability is almost always discerned quite early by the mother although it is often consciously denied and disbelieved. The mother's—and father's—emotional response and overt attitude toward the child go a long way toward the child's emotional adjustment, ego development, and societal relations. Parents may react in different ways. Some, after their initial dismay and sorrow, resolve to treat the child with loving nurture as much like a normal child as is feasible. They seek the help of proper professionals. Other
Parents overreact with pity rather than sympathy. They stifle the child's development with overindulgence and overprotection, preventing his learning to function with useful residuals. In shielding him from the physical and personal world and from gratifications that can only follow minor frustrations which are overzealously prevented, they thwart his normal ego development and potential for social adjustment. A third type of parents is overwhelmed by guilt for producing a defective child, guilt that may stem from actual or fancied transgressions against spouse, religion, or even physician's orders. This guilt may be projected in the form of hatred and rejection of the child or sublimated into overprotection and overindulgence. The guilt feelings of one parent may arouse anger and retribution in the other of sufficient magnitude to disrupt the marriage. This action can intensify the remaining parent's rejection of the child, and the loss of family relations will further harm his outlook on life.

Sexuality

A most distressing feature in the life of a handicapped individual is the distortion, suppression, and often absence of sexual gratification through his or her own disability and because of the emotions and attitudes of others. Sexual libido and cathectic in the psychoanalytic conceptualization begins with the infants' oral drive and sucking reflex, proceeds through an anal stage to the genital stage and finally to heterosexual gratification with a libidinous partner of the opposite sex. Neuromuscular disease or somatic distortion may frustrate the handicapped infant and child in his attempts to gratify pristine sexual urges. Of course, severe mental retardation will usually obviate the need and the desire. When youth burgeons as hormones begin to circulate, even in the physically defective girl or boy whose endocrine glands may very well be normal, eyes and minds wander and yearning sets in.

The pity is that society and even parents so often believe that the disabled youth has no need for sexual gratification. The concept is that he or she should better subliterate all sexual desires into study, training, becoming self-sufficient, and especially not to be burdensome to family or to society. Normal coevals of the opposite sex may feel pity, contempt, or amusement when a defective person feels an attraction and attempts to develop a more personal relationship. Because of the individual's frequent dependence on other members of the family for personal needs, he or she may even have difficulty and embarrassment over attempting to conceal masturbatory relief of sexual tension.

Diamond (9) defined two aspects of sexuality, public and private. The former concerns physical appearance. Sexual patterns and roles are the public demonstration of socially recognized sexual expressions. The private
aspect implies genital sexual responses and inner problems not usually discernible to another person. These include erection, orgasm, receiving and giving genital and sensual pleasures, and reducing sexual tensions in oneself or one’s partner.

Many handicapped young women and young men have a strong desire to marry and to have sexual relations, and an appreciable number do so. Marriage may be with another disabled person or often enough even with a normal partner. There are three reasons aside from the desire for sexual gratification that motivate these persons to seek marriage. Possibly the most cogent is the longing for a lasting meaningful relationship with love and companionship. The second reason is a need to prove oneself as a man or woman. The third reason is the wish to have children, normal children—as proof that they can do this—and to have a normal extension of themselves with the body image that the parents would like to have themselves. These reasons may exist quite separately in different individuals. On the other hand they may be related or even coexist in some.

In any marital or other sexual relation involving a disabled individual there is always the potential for incompatibility. Diamond (9) states that a gap may exist between expectations and sexual capabilities. False expectations can produce severe frustration and consequently arouse marked guilt feelings in the impotent, frigid, or just incapable partner. This may result in resentment and rejection by the second partner or even projection of the first one’s guilt in the form of blaming the other.

When structural physical disability or neurologic inability interferes with orgasmic accomplishment, alternative unconventional means of sexual gratification may be advisable. These methods may be arrived at by the sex partners themselves or may even be instructed by appropriate sex counselors. The achievement of a pleasurable relationship by techniques suited to their disabilities need not be viewed as perversion.

*Humanism and a Multidisciplinary Approach*

Handicaps cannot be cured but their impact can be lessened. Although the terms disability and handicap have been used alternately and often interchangeably, the premise stated earlier in this paper bears repeating. It is appropriate to note that not every disability need be a handicap. Early recognition of defects, the proper multidisciplinary approach and emotional support for the individual and for his parents can go a long way toward habilitation, adjustment, and socialization for the child, the adult to be.

It is worth salvaging those who are salvageable. Those who are not, however, still deserve human and humane consideration even if they will become charges on society eventually. Even a handicapped child is an
integral part of the society in which he lives. There is mutual impact and interaction. The more civilized and advanced a society is, the more tolerant it will be and, sometimes, the more provident it will be. Multidisciplinary approach and action must include special schools that comprise various modalities of therapy—physical, occupational, and speech.

For the adolescent there must also be vocational guidance, sheltered workshops, and special recreational facilities involving young women and young men together. Medical and social agencies must coordinate their efforts and must include the primary physician in planning and treatment programs. The prospectus for any habilitative plan must be problem oriented rather than disease or diagnosis centered. Regardless of the basic pathology, each individual must be treated according to his functional disability and his residual potential. In this way children and adolescents can be grouped more realistically for the greatest efficiency in handling and for optimum social and interpersonal relations among them.

Where psychological and emotional overlay is considered to be a serious addition to the neuromuscular or other disability, psychotherapy may be a valuable adjunct in the rehabilitation regime. The disabled person should be helped to overcome his emotional attitudes about his disability by abreacting his subconscious suppressed feelings and by realistically accepting his limitations and capabilities. In many cases, the parents of the disabled one may also benefit from psychotherapy to resolve their resentments and anxieties with respect to their child, his disability, and how it affects them.

**SUMMARY**

Disability refers to dysfunction resulting from physical or cerebral abnormality. Handicap relates disability to required expectations by the environment. Not every disability need be a handicap. Most behavioral disturbances in handicapped children result mainly from environmental and emotional factors. Psychodynamics of personality and ego development are closely related to motor development. A normal body image concept, so important for normal psychologic performance, is often greatly impaired by somatic or cerebral defects. Imperfect speech and language make communication difficult and aggravate poor social adjustment. The adolescent is depressed by loss of self-esteem and thwarting of socialization and future career ambitions. His superego is beset with guilt feelings over the burden that he presents. From infancy on, the emotional and social adjustment of the individual is influenced by parental attitudes and relations with him. Sexuality, heterosexual relations, and marriage are important considerations for the handicapped person. Multidisciplinary treatment should often include psychotherapy.
REFERENCES


