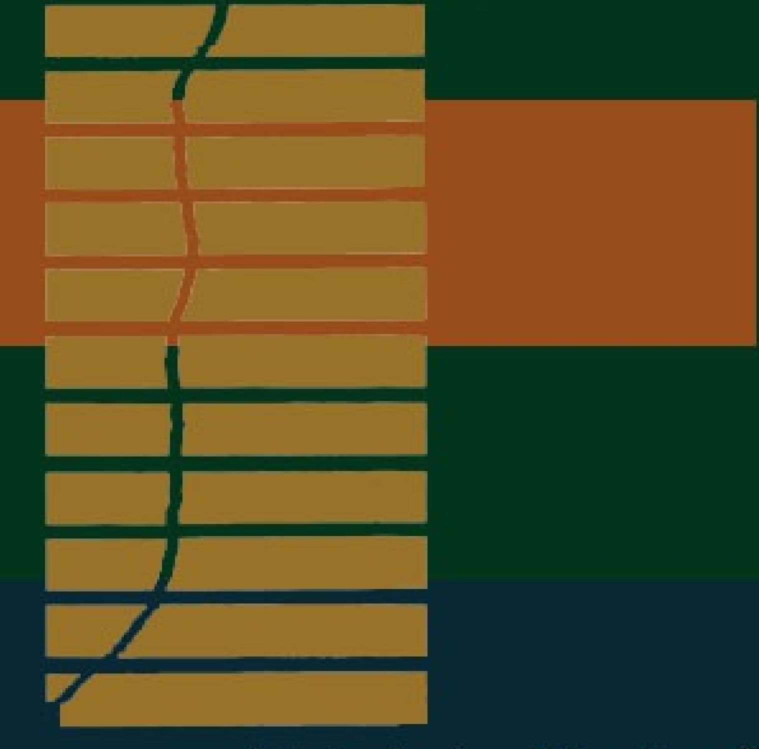
Counseling Physically Challenged Men



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In an era where society worships youth, athletic agility, and the trim, perfect body, the physically challenged male is at a disadvantage. The very traits that society values in individuals are usually traits inconsistent with being physically disabled. Even at an unconscious level, both disabled and nondisabled individuals operate under the presumption that handicapped persons are dependent and helpless (Lindemann, 1981, p. 1). For the male the inconsistency is even more pronounced, because dependence and helplessness are inconsistent with society's view of the ideal male.

It is our purpose in this chapter to increase the reader's knowledge about the special characteristics of the physically challenged male. Initially, we will define disability and present our philosophical approach to counseling. Issues particularly pertinent to either an acquired, congenital, or progressive disability will be discussed. Emphasis will then be placed upon how the male role in particular has an impact upon an individual with a physical disability and the disabled man's relationship with others. Finally, there will be a discussion of general counseling issues applicable to the physically challenged male and suggestions to improve counseling rapport, pitfalls to avoid, and counseling areas to pursue.

Definition

Many individuals are viewed by others as disabled but do not consider themselves disabled. Whether or not one considers himself or herself disabled depends a lot upon how one defines disability. Wright (1980, p. 9,68), in his definition of disability and handicap, says:

> A disability is any physical, mental, or emotional condition that is chronic or long-lasting (not acute or temporary), which is severe enough to limit the individual's functioning, and which results in, or threatens to be, a handicap to productive activity. . . . A handicap is a disadvantage, interference, or barrier to performance, opportunity, or fulfillment in any desired role in life . . . imposed upon the individual by limitations in function or by other problems associated with disability and/or personal characteristics in the context of the individual's environment or role.

Thus a person with a disability may not be handicapped given certain roles or in certain environments, for key words in the definition of handicap are “limitations . . . in context of the individual’s environment or role.” For example, the famous violinist Itzhak Perlman, who is mobility impaired, is not handicapped in his role as a violinist, but he would be handicapped as a soccer player.

The words “physically challenged male” may include much of the male population if used in its broadest sense. To limit the topic, emphasis will be placed on men who are mobility impaired, particularly those men who use wheelchairs.

Theory

Disabled men have been thrust into their disabling condition in a fashion that is out of their control; however, disabled persons have the potential to choose their way of life and therefore to change, to function more effectively, and to improve their quality of life. Certainly one would not choose to be mobility impaired; however, there are choices to be made throughout life.

As counselors for those who are mobility impaired, it is our goal to help facilitate change by dealing with issues that can interfere with a positive self-image, by focusing on what an individual can do, and by expanding on the existing personality. Focus should not be placed on limbs that do not function well but rather on the man as a total system. At the same time, ignoring the impairment would also be inappropriate. Linkowski and Dunn (1974, p. 31) suggest that “perceptions of disability are a significant and central aspect of the self-concept, relating to both self-esteem and satisfaction with social relationships.” They go on to suggest that a Gestalt rather than an analytic approach is more appropriate for the understanding of the relevance of a disability for those who are disabled.

Acquired Disability

The professional who counsels individuals with acquired disabilities must be aware of the inherent demands—both physical and emotional—the psychological stresses, and the limitations and frustrations imposed by this type of disability. Acquired disabilities can come in several forms, including spinal cord injury, stroke, polio, head injury, and loss of a limb. For purposes of this section we will use the example of spinal cord injuries to exhibit many of the problems encountered with other acquired disabilities.

Those who experience spinal cord injury have many short and long-term needs that are over and above their physical/medical concerns. The severity of injury is the best predictor, at present, of the number of difficulties the person will encounter. Dew, Lynch, Ernst, and Rosenthal (1983) report that, in general, the severity of impairment increases the higher the level of the lesion; however, depending upon the area and degree of damage of the spinal cord, loss of sensory and motor functions vary.

According to Bray (1978) spinal cord injured individuals go through a lengthy four-stage adaptation process that resembles the mourning process. The actual time involved depends on the flexibility and motivation of the individual and the support services available. Anxiety, the first stage, lasts about nine months. During this time the person requires reassurance of survival, help in focusing on the present, and encouragement to function within present ability level. The second stage, which lasts about 14 months, is that of accommodation. This is a time for reconciliation of differences and realizing of a changing lifestyle. Three years post-injury is usually when one enters the third stage, assimilation. By this time the person has regained all the sensation and motor control possible. This stage centers on growth, challenge, and change. Assimilation continues throughout life. The fourth stage is referred to as reflux. It can be experienced at any time in the process but is not necessarily experienced at all. Reflux is a regression to an earlier time due to a serious physical, emotional, or financial difficulty. Successful adaptation requires a reworking of all subsequent stages. An understanding of the stages of adaptation facilitates more effective counseling of the spinal cord injured.

Each traumatically injured individual does not necessarily go through the four-stage adaptation process in exactly the same fashion. Each has his or her own set of problems. An example is a young man named John whose adaptation process illustrates the four stages as well as illustrates his particular problems. John was involved in an automobile accident as a college freshman that resulted in quadriplegia. John’s initial hospitalization did not go well. He had developed several decubitus ulcers (bedsores) that had prevented his active participation in the therapy program. Despite reassurance from the rehabilitation staff and family about his future, John vacillated between bouts of severe depression, angry outbursts, and unrealistic expectations about walking again. Finally, at the rehabilitation center, John’s decubiti began to heal to the point where he could use his motorized wheelchair. He was confronted with individuals in various stages of rehabilitation, and ultimately he began to realize the inevitable change in his future lifestyle. With support from staff, family, and friends and a positive but realistic environment, John began to adjust to his new circumstances. About a year or more later when John came back to the rehabilitation center for a routine urological checkup, he shared his plans to change his college major from physical education to business. He later graduated and got a job working at a bank. Unfortunately, his enthusiasm and desire to succeed in his new job caused him to overlook aspects of his skin care, resulting in a reoccurrence of decubitus ulcers. He then required extensive hospitalization for plastic surgery to heal his skin. Again, John became depressed and anxious about his future. He relived some of the initial stages of adaptation, but ultimately he recovered. John is presently a successful banker who now realizes that he must continuously monitor his own health.

The criteria for success and adjustment for those who are spinal cord injured may not be the same as the criteria for the nondisabled. Roessler (1978) suggested that some of the necessary components to successful rehabilitation include a positive orientation toward life, goals that are realistic, and a sense that the goals can be accomplished. However, a realistic goal for spinal cord injured persons may not necessarily be a return to productivity as indicated by employment. Dew et al. (1983) suggested that other criteria such as self-care skills acquisition, volunteer work, and recent employment of other family members may be better indicators of success for spinal cord injured persons.

Individuals with spinal cord injuries are frequently characterized as impulsive, rebellious, nonconforming, and difficult rehabilitation clients (Athelstan & Crewe, 1979). Malec (1985) found that the traumatically injured are extroverted. Athelstan and Crewe (1979) suggest a relationship between these personality traits—that is, impulsivity, rebelliousness, nonconformity—and the occurrence of the spinal cord injury. At the same time they found that the personality characteristics related to injury acquisition were correlated with successful adjustment.

Counselors for spinal cord injured individuals may be involved with formerly physical, rebellious, streetwise males who may defy traditional middle-class values. An understanding of personality characteristics may facilitate better adjustment success. Malec (1985) suggested that due to the personality characteristics of spinal cord injured individuals it would be better to encourage active participation in the rehabilitation process on the part of the clients rather than introspective counseling and psychotherapeutic efforts.

Congenital Disability

Children with congenital disabilities grow up to be adults with congenital disabilities. Cerebral palsy and spina bifida (or myelomeningocele) are the two most frequent congenital disabilities causing mobility problems.

Many of those with a congenital disability face problems similar to those with an acquired disability; however, there are in addition a unique set of concerns. Lindemann and Boyd (1981, pp. 127,252) described the presence of increased maladjustment including anxiety, withdrawal, poor self-esteem, and dependence for those with cerebral palsy and spina bifida. They go on to describe difficulty with mother-child bonding, which promotes fearfulness, passive timidity, and withdrawal in any child. Parental overprotection can also incapacitate the congenitally disabled adult. Tarnow (1984, p. 70) suggested that a sense of autonomous, competent self cannot be fully developed if overprotection occurs. This may result in individuals who are unable to take care of themselves or exhibit acting-out behavior.

Individuals with a congenital disability may not have some of the same experiences or opportunities as the nondisabled. In some ways they may be culturally deprived because of the lack of experience. A study conducted by Hayden, Davenport, and Campbell (1979) suggested that adolescents with myelomeningocele take little responsibility for chores they could physically perform at home. Their investigation showed that these adolescents often have prolonged hospitalization and are behind in school. As a result they tend to interact with younger individuals. They participate in fewer team sports, group, and extracurricular activities and have fewer close friends than the control group that was part of the study. This type of experiential deprivation is detrimental to independent living and psychosocial maturation.

The individual who has a congenital disability may experience social isolation and as a result develop inadequate social skills. In addition, the quality of social relationships may be limiting since interaction with disabled persons may consist of patterns of support, assistance, and reduced expectation. A disabled individual may develop the attitude that he or she is the center of the universe, and thus the natural give and take of a relationship is not developed. This individual may not assume personal responsibility for a relationship and then expect others to initiate and maintain the relationship (Easton & Halpern, 1981, p. 147). As a result others may be reluctant to interact meaningfully with an individual who lacks social skills, is egocentric, and who does little to enhance and maintain a relationship.

When counseling those with a congenital disability one should consider that the disability can cause intrinsic psychosocial disabilities. For example, cerebral palsy can cause difficulty with retention, acquisition, interpretation, and application of information. Verbal receptive, verbal expressive, visual perceptual, and visual motor impairments can be present (Easton & Halpern, 1981, p. 147).

Despite the unique set of problems, congenitally disabled individuals frequently do not have some of the adjustment problems of the traumatically or progressively disabled. For those who are congenitally disabled, there is not the longing for what used to be. The congenitally disabled person may envy those who are able-bodied; however, they have never lost any abilities, as someone who is traumatically disabled.

Many congenitally disabled individuals are functioning as productive and well-adjusted adults. For one particular individual with spina bifida there has always been the focus on abilities rather than disabilities. Jim is mainstreamed in the public schools. His academic abilities allowed him to compete with his classmates. While able-bodied friends are participating in athletic pursuits, so is Jim. He participates in competitive swimming for the disabled and has won numerous awards across the country. He has been encouraged to baby-sit for neighborhood children. In the summer he volunteers at a center for autistic children, and eventually Jim would like to go into special education.

Progressive Disabilities

There are numerous chronic and progressive diseases that cause mobility impairment. The diseases that are often associated with a progressive nature are multiple sclerosis and muscular dystrophy. Both of these diseases, as well as others, are characterized by decreasing physical abilities, changes in appearance, loss of key roles, the need for medical attention, and an uncertain future (Pavlov & Counte, 1982). For these individuals there are continuous and unrelenting changes and adjustment occurring throughout life.

Individuals with a progressive disability vary. Pavlov and Counte (1982, p. 141) said, “There is considerable variability in adaptive success at any particular level of disability.” Those who are mildly disabled may have more adaptive distress than those who are severely disabled, for the mildly disabled may be more anxious about the future. Tarbell (1980) suggested variability when she described a wide range of symptoms and differences in residual functional capacities. The course of a progressive disease is also variable. Some individuals exhibit a steady worsening condition without remission, and some experience many years between exacerbation (Kraft, 1981, p. 112). A counselor should consider the relationship with a disabled client in the light of remission or exacerbation. The behavioral expectations of the client may be different during remission than during exacerbation.

During remission individuals may more easily deny the disability, whereas during exacerbation increased depression may occur. Mclvor, Riklan, and Regnikoff (1984) suggested that individuals with multiple sclerosis who experience at least one remission were less depressed than those who never experience a remission.

Individuals with a progressive disability have often been characterized by increasing social inhibition, passiveness, and depression (Harper, 1983). Social isolation is frequently associated with a progressive disability. These characteristics appear to be related to the realities of decreased mobility and reduced social interaction (Harper, 1983). Facial muscles may be affected in some individuals with some types of muscular dystrophy, and an individual may not be able to smile or give appropriate facial response (Lindemann & Stanger, 1981, p. 285). Motor weakness may interfere with nonverbal communication. An individual with multiple sclerosis may experience mental changes, that is, euphoria, intellectual deterioration, and lability of mood (Kraft, 1981). As a result of all these physical characteristics and situational characteristics, the individual with a progressive disability is often isolated and may be socially inhibited.

Another period that Lindemann and Stanger (1981, p. 286) suggested as a period that is particularly difficult is when those with a progressive disability are required to use a wheelchair. Frequently, these individuals become quietly depressed at this time (Lindemann & Stanger, 1981). The progression of the disease cannot be denied, and the individual must face the reality of the disease.

Finally, it should be emphasized that individuals with acquired, congenital, or progressive disabilities can be well-balanced, happy, and productive individuals. Again, the variability of those with disabilities must be stressed.

General Issues Related to the Physically Challenged Male

THE MALE GENDER ROLE

The gender role appears to play a significant part in an individual's adjustment to a disability. Our society's expectations for men make it more difficult for them to be disabled (Skord & Schumacher, 1982). Therefore, due to societal expectations, disabled men frequently behave in ways that are often contradictory to effective rehabilitation.

Liss-Levinson (1982, p. 326) states that "the traditional male sex-role dictates that men are rational, independent, and capable of handling any and all crises." "Men are . . . expected to be healthy, vigorous, strong, and sexually rapacious . . . . Men are generally expected to be powerful and in control of themselves and of their situations at all times" (Scher, 1979, p. 252). Men are not socialized to ask for help or accept help, to be emotional and dependent.

When a man changes from able-bodied to disabled, many of the roles he is accustomed to playing become inconsistent with the disability. This change can cause the individual to feel that he has lost control of his life. This loss of control is made worse by the disabled man's perpetual dependency. Dependency is in contrast to a society's image of the self-sufficient male.

THE DISABLED MAN'S RELATIONSHIP WITH OTHERS

There is a strong correlation between a supportive family and the successful rehabilitation of disabled individuals. Mclvor et al. (1984) found in their study of depression in multiple sclerosis that severely depressed individuals perceived less family- and friend-based support than those with less depression. Reagles (1982, p. 27) suggested that "the family's willingness to mainstream or reestablish a disabled person's role is an important source of motivation for rehabilitation." Thus the nature of an individual's relationship to significant others may strongly influence an individual's adjustment and ongoing life as physically disabled.

If family members, including the disabled male, can be flexible and adjust to new norms, expectations, resources, and roles, they will be better able to remain intact as a family and at the same time the disabled male’s chances for successful rehabilitation will be increased. According to Reagles (1982), if one member of the family is chronically ill or physically disabled, roles need to change in order to facilitate family adjustment. As a family works toward developing new roles and status, care must be taken that new roles are acceptable to all involved. At the same time, the male as well as other family members must take care that the newly developed roles are not roles that are destructive. The disabled male must not be treated differently from other family members. He must be allowed to maintain or reestablish a major family role where he is a contributor, not just a receiver.

On a daily basis, disabled men interact with people who are not significant others. These interactions may be brief passing encounters or daily encounters, such as with a van driver or attendant. Frequently the individuals encountered are sensitive and caring individuals. There are many, however, who are caring but not sensitive. For example, in a restaurant setting, the waitress may ask a nondisabled companion what the disabled individual would like to eat. The implication is clear that the disabled individual is not capable of ordering his or her own meal, and this is demeaning to the disabled individual.

Also of importance to the disabled male are sexual encounters. For most disabled men, the ability to relate to others sexually is important to their identity of being male. Much has been written concerning the sexual issues of mobility disabled men, particularly for those who are paraplegics and quadriplegics. Despite this wealth of literature, the disabled individual is often considered sexless; however, Halstead (1984, p. 235) stated that it is a myth “that disabled people are uninterested in sex, do not function normally anyway, and might hurt themselves if they tried.”

Stewart (1981, p. 348) said that, “disruption and disfigurement associated with a disability need not destroy the heart of sexuality—the capacity to share pleasure and vulnerability with a loved one.” For all people there are no correct ways to have sex. For men who have experienced a spinal cord injury, there is a need to explore the body’s sexual response both with and without assistance (Robbins, 1985). New erogenous areas become apparent. For many there is more planning and some preparation before sexual encounters can take place.

Men who are spinal cord injured have reduced or no sensation below the level of injury. Those individuals with incomplete spinal cord lesion may have some sensation, however, those with a complete lesion or those with spina bifida will have no sensation below the lesion (Sandowski, 1976). Most male paraplegics or quadriplegics will be able to have an erection; however, reports vary. It should be emphasized that the inability to have an erection and ejaculate does not mean that the disabled man cannot experience some form of sexual gratification.

“Healthy sexuality... is a part of a healthy self-image” (Cole & Glass, 1977, p. 586). Healthy sexuality and a healthy self-image are both possible for the disabled man who has a good sexual knowledge base and who uses remaining functions whether cognitive or physical.

APPROACHES TO COUNSELING DISABLED MEN

There are some practical approaches to counseling the physically disabled male. One must definitely take into consideration that counseling a male must be somewhat different from counseling a female. Ignoring this difference may jeopardize the counseling relationship. Weinberg (1979) suggested that the disabled and nondisabled are socialized into similar gender roles. She says that an individual’s gender has more influence on an individual’s self-perception than a disability. Thus it is in the best interest of the counselor and client and their relationship to consider the needs of a male and the implications of male role expectations when counseling the physically challenged male.

Wong, Davey, and Conroe (1976, p. 59) suggested that a positive approach to counseling men would be “to start with the idea of strengthening and expanding on the already masculine base.” Liss-Levinson (1982, p. 328) also suggested that a counselor should “work within the context of the traditional sex-role.” For example, men are socialized to be in control. Exploring acceptable ways for a disabled man to be in control, whether over personal care and/or environment, will allow him to exert his masculinity.

Somewhat related to the idea of a male role is eye contact. Males do not generally like to be dominated or placed in an inferior position. As a counselor it is wise to stay in a seated position when conversing with an individual in a wheelchair so that the person will not have to look up to maintain eye contact.

Another pitfall to avoid when counseling the mobility impaired male is the avoidance of the parental role. There is no need to be condescending, protective, controlling, or too helpful. The parental role is inappropriate for the nondisabled and disabled as well. “If someone always insists on taking a difficult but learnable task out of the disabled person’s hands, the person may be deprived of the opportunity to learn how to function alone (Ker, 1984, p. 153). It may be helpful to work together to set realistic goals or to explore activities and behaviors that have not been tried before.

Many disabled individuals have developed successful techniques on how to manipulate others. Some use secondary gains or learned helplessness in their efforts to control others and as a way of getting out of tasks they can do themselves. Often they are not aware of their behavior. Wright (1980, p. 546) stated that “‘secondary gains’ refers to the external, additional gains derived from disability.” Learned helplessness is when an individual who is disabled picks up cues from those around him or her as to what he or she is able or unable to accomplish.

A disabled man requires good communication skills. Most people are dependent on communication skills. However, they are even more important for the disabled individuals. Maxwell, one of the chapter authors, learned this just shortly after his injury. Friends and family were very supportive of him, and they visited him while he was strapped to a circular electric bed with tongs and traction attached to his shaven head. Prior to the visitation the visitors would be briefed by a nurse, but no matter how well the visitors were prepared, they were uncomfortable with the “new” Dick Maxwell. After a brief exchange of recent news, there was silence, uncertainty, and possibly fright. Finally, Maxwell had to “break the ice.” He had to help them to feel more at ease, and this has become a constant in his life. He had to react to able-bodied persons to help them adjust to his disability. Later, he had to work to help others see the man beyond the hum and chrome of a motorized wheelchair. The necessity of good communication goes beyond the disabled man’s desire to get his needs met; it is vital for the securing and maintaining of good interpersonal relationships.

Finally, the counselor needs to focus on the entire person, not just the disability. At the same time, the disabled client needs to shift his perception of self from the disability as the major focus of identity to the periphery so that the true personality will be the major focus. By this acceptance of the basic personality as self, the disabled person will be better able to help those around him shift from focus on the disability to focus on the more positive aspects of self, as suggested by Cogswell (1984). Ultimately, disabled men do not want to be treated like disabled men. They want to be treated as individuals.

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