The Journal of Sociology & Social Welfare

Volume 4
Issue 5 *May*

Article 4

May 1977

The Non-Verbal Communication of the Physical Handicapped

Mary Jo Deegan
University of Nebraska, Lincoln

THE NON-VERBAL COMMUNICATION OF THE PHYSICALLY HANDICAPPED*

Mary Jo Deegan, Ph.D., University of Nebraska--Lincoln

Abstract

This paper explores the types of problems which may arise as a function of a physical disability and its effects on non-verbal communication. Examples of social interaction problems were obtained through participant observation at a physical rehabilitation hospital. The author assumes that social skills based on communication through and by the body need to be conceptualized and have implications for their use in therapeutic settings.

Numerous writers and observers of daily life have commented upon the strained interactions between the physically disabled and the non-disabled. This tension has been attributed to negative stereotypes associated with disability (Barker et al., 1953), deviant status (Freidson, 1966; Davis, 1962) and stigma (Goffman, 1963). Here, this flawed interaction is discussed as a function of distortions, interruptions, and erroneous information conveyed by the presence of the disability. This means that the disability takes on social meanings and consequences which impinge on the ability to communicate.

This paper is an exploratory study to apply the concepts of non-verbal communication to the problem of social interaction between the disabled and the non-disabled. Due to the need to first define the problem, it is not possible here to suggest a program for direct action. Despite this time and space limitation, it is important to note that the author assumes that social skills based on communication through and by the body need to be conceptualized and taught to the disabled in a manner similar to the therapies developed for rehabilitating impaired motor and speech skills. This research is a step in that direction.

METHODOLOGY

Participant observation was done at a large, urban physical rehabilitation hospital serving both in-patients and out-patients. The volunteer role was used in this setting from June, 1973 to March, 1974 (Deegan and Nutt, 1975). Observations were made in approximately two

hour periods, and field notes were then typed in a neighboring facility. The observed patient population consisted of approximately 350 patients.[1] They presented a wide range of physical disabilities including strokes, spinal cord injuries, amputations, cerebral palsy, and multiple sclerosis.[2] Both sexes, all age groups, and a variety of races, predominantly white, were represented. Since the hospital was both public and private, all socioeconomic classes were included.

CONCEPTUAL FRAMEWORK

Non-verbal communication (NVC) is a term used to cover the socially derived meanings of an extensive range of human behaviors, e.g., facial expression, movement, gaze, and gestures.[4] The significance of such body orientations and action is due to their information concerning 1) attitudes towards the self, 2) attitudes towards others 3) social placement in interaction, and 4) social placement in the wider society.

Every person becomes an object to himself by taking the attributes of the "other" toward himself, and this attitude, in turn, is tempered by his physical presentation (Mead, 1934). In fact, if Cooley's "looking glass self" is taken literally then the role of the body in developing one's self image becomes apparent (Cooley, 1902).

The presentation of self embodied in a flawed physical presentation "spreads" the physical imperfection into a flaw in social interaction (Wright, 1960).

> Indeed, "adequate" performance in interaction situations is the acid test of eligibility for the status of full fledged humanness; the misfit, the handicapped, and the psychologically disturbed are defined by the degree to which they impeded "normal" human interactions (McCall and Simmons, 1966:1).

Within everyday life there are standards of behavior for self presentation (Goffman, 1959). We try not to let our faces sag when we meet people; we hold our hands steady when we extend them for a handshake; we try to sit in the most comfortable spot, and we stand when we are ready to leave. All or some of these interpersonal signals may be altered by a physical limitation.

The significance of these movements for indicating attitudes towards the self have been noted by Freudian psychiatrists (Deutsch, 1952; Dittman, 1965; Scheflen, 1965). In using postural reactions and

studying standard configurations of behavior for different situations and settings, psychiatrists use this information in therapy to reveal self concepts and social actions to the client. This body of literature is a valuable source for the social scientist who wishes to examine norms and their violations.

The everyday interpretation of bodily movements as indicators of social status, sexuality, and participation in group contexts have been popularized in a number of books (Hall, 1959, 1966; Fast, 1970). Another "popular" source for learning about social norms is etiquette books. More technical attempts to study NVC are found in Birdwhistell (1970), but his work is not useful in this study of behavior on a macro-level.

Given the existence of norms for daily behavior and the problems of enacting these norms for the disabled, then the conduct of the disabled when he breaks these norms may be considered deviant (Lemert, 1951). Yet the assignment of the deviant role to the handicapped has always been problematic. For the presence of a handicap raises situation-specific questions about the origins and intentional meaning of these actions (McHugh, 1969). Davis (1962) finds that the physically handicapped must "disavow" this deviant status to allow for smooth interaction between the disabled and the non-disabled. This process of establishing oneself as a "normal" participant is interpreted here as a function of NVC patterns which include defining the "disability" and not the "self" as the source of "deviant" body movements. In other words, these flaws in interaction can be defined as "unintended" by the actor reducing or eliminating his deviant status.

When the disability is not easily recognized as the source of norm violation, then the meaning of the NVC becomes interpreted within other contexts, e.g., as an indication of an expressive state, as a sign of discomfort with the social situation, or a lack of poise. That such interpretations do occur has been supported in a study of children who gave unfavorable judgments of pictures of the movements of disabled children who were not identified as having physical impairment (Winkler, 1931). This ambiguity in communication leads to strained interaction and a "marginal" role for the disabled (Barker et al., 1953).

The convergence of theories of "normal," everyday behavior; definitions of the "self" arising from the opinions of others towards "me;" the studies of NVC; and responses to unusual or "bizarre" body motions support the statement that the NVC of the physically handicapped is interpreted in social interaction. The ambiguous information supplied

by the disabled--that is, is this information a cue from the person or is it an unintended cue of his bodily impairment--can lead to awkwardness, bewildered responses, and avoidance by the non-handicapped. Examples of the intrusion of "unintended" and ambiguous messages are presented below

THREE GENERAL PROBLEMS OF NON-VERBAL COMMUNICATION AND PHYSICAL HANDICAPS

Cleanliness

The significance of personal hygiene in presentation of an acceptable "human" self is particularly strong in America (Miner, 1956)[7]. Norms of personal cleanliness are so thoroughly internalized and enforced that it is uncommon to be confronted with long-standing personal dirt. Social responses to people with dirt on clothing, on the body, or on attendant equipment are strongly negative.

With the physical limitations of some disabled persons, efforts to maintain personal cleanliness are tedious and time-consuming; for others, they are impossible. Those who are highly dependent on others' care exhibit a wide range of body dirt and odors. For example, two men who entered the hospital from another institution were so filthy that the doctor had to use a scapel to clean their feet prior to his examination. After they passed through a room the air was sprayed to remove the odor (or conceal it!), and people passing through these rooms would mention the foul odor and inquire about its cause. Needless to say, it was hard to induce hospital personnel to work with them and one receptionist refused to stay in the same area with them.[8]

Another male out-patient was elderly and lived in yet a different institution. His clothing was soiled while his body, particularly his face, was exceptionally clean. His dependence on others for self-care was an irritant to him as well as to others. People, predominantly other patients, avoided sitting next to him. His self presentation was a source of gossip reflecting the general opinion that he was "unpresentable."

Both of these instances of bodily dirt show the extreme responses elicited as a function of uncleanliness. The latter example is especially instructive in showing that "spread" occurs among patients, too.

Eating

As a form of human and social behavior, eating has a number of communication functions. The act of feeding oneself is strongly associated with being an adult. It reflects individuality through the manner of

eating, choice of company, selection of food, and so forth. Table manners are linked with definitions of a pleasant meal, and disabled persons with problems of jaw and/or facial muscles break many norms of etiquette. For example, difficulty in swallowing foods may result in "startling" head gestures, such as throwing the head back to allow food to pass down the throat. A man with cerebral palsy describes in detail his attempts to eat and stay clean:

> At the age of 29 I was able, for the first time, to bite a slice of bread and butter. Even so, I got food on my face and hands in the process. THerefore, spearing small pieces with a sharp fork is better, especially when I am with other people. I drink through a tube. If I drink from a cup I can't manage to swallow at the beginning and the liquid is likely to overflow from my mouth...I eat with my mouth open. I can chew with my lips closed only when I am completely free from reflexive movements or am very tired. Brittle food (like toast) is easier to chew than soft (desserts that fill the mouth, lettuce). (Ondrak, 1970: 323).

The particular problems in eating for those unable to direct the food to their mouths are severe, resulting at times in an unwanted communication of "animal" behavior. This association with animal rather than human norms is reflected in a comment by a hospital worker about a patient: "If he ever came to my home, he'd get a doggie bowl." Although a "doggie bowl" would perhaps be a sensible way to facilitate eating, cultural sanctions are too strong to overcome the associated negative communication.

Problems of self presentation while eating are often so acute that those who can feed themselves may refuse to eat in public either foregoing eating or asking to be fed. This primarily occurs with quadriplegics and cerebral palsy patients. After refusing to eat in a cafeteria, several out-patients with cerebral palsy would eat or at least sip something to drink if they were taken to a more private room within the hospital. Being fed by another person produces its own set of problems, too; the difficulty in asking another's help, waiting for the person to be available, being unable to control the size of food eaten, selecting the food, and so forth. However, this dependency and presentation of self as "infantile" is preferred by some people rather than feeding oneself "like an animal."

Clothing

The selection of style and type of clothing is recognized as an

important form of self presentation (Stone, 1959, 1962), and it may be greatly circumscribed for those with physical disabilities. Close-fitting styles may be impossible to wear because of interference with body motions or equipment; buttons may be impossible to manipulate; supportive shoes, braces and bandages interfere with aesthetically pleasing movements or images. Women have notoriously poor shoes for postural control and foot protection, and the disabled woman may thus find it hopeless to integrate her feet with a fashionable presentation of self. The role of feet in a projected self image is expressed by black, male patients who wear platform shoes. From a functional point of view, it is incongrous for a wheel chair patient since this style is particularly hazardous for the maintenance of balance and good posture. From an interactional perspective, it is a striking and effective presentation of normality because the person appears to be sitting in, rather than being confined to, the wheel chair. Clothing selection, however, for many patients must be made by others, thereby conveying erroneous information about the person. For example, there was a blind woman in her mid-twenties who looked and dressed exactly like her fifty year old mother.

Another ambiguous situation about clothing selection occurs when a non-disabled person interacts with a disabled person who has selected "good" or acceptable clothing that conveys negative information. One patient had put considerable time, effort and pride into making a leather belt which was well constructed and designed but which, unforeseen by the therapist or the patient, accentuated the deformity of his waist. The patient's pleasure and desire for a positive response created a dilemma for others: should the belt be complimented without reference to its effect on the person's appearance or should a different use of the article be suggested? The behavior that emerged was a series of vague and brief comments by others which might have mistakenly be interpreted as an avoidance of the person rather than of this problematic situation.

SPECIFIC DISABILITIES AND PROBLEMS IN NON-VERBAL COMMUNICATION

Cerebral Palsy

The person with cerebral palsy who exhibits spasticity (violent and involuntary contraction of the muscles) has extreme problems in presenting himself as a thinking, intelligent individual. To observe spastic movements is to confront a myriad of unacceptable body motions.

It is easy to see how the "spread" (Wright, 1960: 118-24) between lack of muscle control and lack of mental control occurs. Many spastic

facial expressions are socially associated with various emotional and physical states, e.g., pain, anger, dislike, and so on. They convey the appearance of being mentally agitated. Certain movements, such as flailing arms, are usually defined as a sign of extreme excitement, and often of distress. Some motions would not be found at all within the American repertoire of body movements (Hall, 1959). Because of past experience with negative evaluations of self presentation, the person with cerebral palsy may enter a social interaction anxious and nervous. This fear, in turn, physiologically increases the spasticity.

For the "other" to interact with such uncontrolled movements is to witness a complex, meaningless, agitating signal that demands some response. It is difficult to draw the line between ignoring meaningless stimuli and ignoring the person. The author finally resolved this dilemma by occasionally looking away and occasionally looking towards the person's head. This allowed for possible contact without appearing to stare at the person or to ignore him completely or--equally impossible--to try to follow his head movements. One person with spasticity tried to consciously control his head movements and he returned sporadically to the original point of eye contact. This required considerable effort and was unattainable for some.

Despite the importance of eye contact signals in communication, and despite the knowledge that spasticity is physiologically, not psychologically, based, there are few norms that deal with the flow of communication in this situation.

Amputation

Persons who have suffered the loss of a body part have lost a method of communication. Major and minor shifts in posture, movements indicating pleasure or displeasure, patience or impatience, and so on cannot--by definition--be reflected in the missing part. The socialization process which has occured throughout the person's life has trained him to learn to use his body for interpersonal signals, and the adult with a recent amputation must unlearn, relearn and create new information channels.[9]

In addition to this process, another is simultaneously occurring: the affected part and the entire body may communicate unintended information. Movement which is lost may signal to the other that the person isn't responding, or is responding inappropriately. On one occasion a person at a table asked a man with a double arm amputation to pass a cup of liquid down the table. Since he was able to do similar actions, but was possibly uncomfortable about his ability to avoid

spilling the liquid, he acted as if he didn't hear. Again, it is necessary to conditionally explain behavior in light of physical capabilities because many of these behaviors are only potentially a function of the disability. Embarrassment over one's ability to move or present oneself gracefully may lead to situations where the amputee avoids shaking hands or reaching for a desired object, or walking across the room to help another person. Yet the other person can only infer the possibility of such a reason within a matrix of other possible ones: rudeness, lack of friendliness, or a desire to be alone.

When there is no prothesis to fill out the missing shape, the person with a visible amputation presents a "less than whole" image. Such an individual may sit in an "unusual"way, i.e. too close to the side of the chair, or without shifting the missing part, or not reacting to the side of the body with the amputation in the same way he responds to the other side. Many studies have been done concerning the importance of "body image" to the person following an amputation, but similar studies have not been done on the significance of body image to the non-disabled observer.[10]

A major non-verbal signal sent by an "incomplete" body is vulnerability. The potential for bodily injury shared by the non-disabled is conveyed by the reality of the amputee. One way of minimizing the threatening nature of this confrontation is the use of prostheses. These can be hooks or cosmetic hands or artificial legs. While a great deal of mobility and function may be gained through their use, certain movements may be limited by prostheses. How does one express sympathy or tenderness through a hook? In turn, the non-disabled may be uncertain about what is appropriate in the reverse situation.

The movements made possible through prosthetic devices are usually slower and less smooth than the normal body's movements. The person can appear awkward and clumsy. Slowness in action can "spread" to an association with slowness in thinking. Similarly, when the slowness and possibly uneven gait of an amputee is matched by a non-disabled person's tempo, the incongruence in rates may be irritating. Despite allowances for the disability, the non-disabled may feel that he is "wasting time," that the other "is getting on his nerves," and that he is controlling his behavior.

Wheel Chair Bound

The fixed position and limited maneuverability of the wheel chair bound is dominant in many interactions. The person in the wheel chair is always seated, even when others stand. This obvious physical differ-

ence in self presentation may mean that the person experiences both figuratively and literally that he is "being talked down to."

In addition to limits on movement, the body may be shifted because of physical discomfort from being seated continually. Such shifting may erroneously signal uneasiness or boredom. One woman left a gathering very abruptly. She later explained that she had been worried about people hitting her extended leg. She didn't want to push others away or constantly remind them to avoid her leg, so she chose to leave. Her sudden leave-taking had mistakenly appeared to the researchers as an indication that she had felt "left out" of the activities.

Other limits on interaction occur when the wheel chair bound person is caught in a situation where he can't leave unless others move or help him. This occurred when a woman was left in a wheel chair while the people she was with went on another errand and were delayed for two hours. Since this woman could only be seated for a two hour period (after this time she needed to lay on her stomach to prevent the development of pressure sores), she had to return to the hospital disappointed and angry.

People who use urinary bottles may not attend social occasions if they cannot enter the bathrooms due to architectural barriers and they don't wish to ask others to empty their bag or bottles. Explanations of the problem may be as embarrassing to some people as the act itself. Yet if these explanations are not given,other interpretations of their behavior are likely to be made.

SUGGESTIONS FOR APPLIED RESEARCH

In light of the framework developed above, a few brief illustrations of its applicability in rehabilitation settings are presented.

A potential source for compiling a repertoire of skills already exists in the large number of autobiographies which have been written by the physically handicapped (see Goffman, 1963 for a list of such biographies). Practical knowledge gained from daily living could also be obtained through the deliberate effort to compile such information through the use of interviews and discussions of specific situations such as those presented here.

Application of this knowledge to the newly disabled in rehabilitation settings would be one possible way to ease the transition from pre-disability to post-disability activities. Although many problems in daily living are successfully taught in physical and occupational therapies, the norms of sexual and dating behavior, social grace, positive self presentation and how to handle awkward social interactions are not

emphasized as much as the gaining of motor skills.

The preparation of movies and video tapes which deal with these situations and their possible interpretations and solutions would be another method for opening this area to discussion and pssible change. One potential benefit of this approach would be the emergent definition of the situation as one of confusion and rejection certain behaviors due to violations of social norms and expectations and/or ambiguities and not due to the underlying prejudice against the disabled and their "stigmatizing" attributes. This opens up the possiblity for dialogue rather than confrontation.

CONCLUSION

The role of the body in social interaction is an area of sociological inquiry which remains to be adequately treated in theoretical concepts and empirical research. Therefore, it is particularly difficult to study the abnormal when the boundaries of normal interaction are relatively uncharted. Hopefully this paper articulates an area of study which is both theoretically innovative and capable of being applied to therapeutic settings.

FOOTNOTES

* An earlier draft of this paper was read by Odin Anderson, Ronald Andersen, Norman McQuowan, Gary Albrecht, Milton Singer and Marie Vogel. Thanks is given for their comments and support while the author assumes responsibility for the final draft and form as it appears here.

[1] This is an estimate of the number of in-patients and out-patients encountered by the researcher during the 9-month observation period. It is based on research notes and attendance at various hospital activities. The total hospital population during this period would be well over 1,000.

[2] Due to the nature of the population, motor disabilities are examined. Similar problems in non-verbal communication would occur with sensory disabilities with distortions in communication arising from impaired senses rather than impaired motor skills.

[3] More specific statistical breakdowns of the demographic characteristics are available from the author. Because of the exploratory nature of the paper, greater detail is omitted. A sub-population within the total sample, comprised of 64 patients, was used to study the effects of a traumatic injury to an adult's identify. See Deegan 1975.

[4] "Gesture" is a significant term in Mead's social psychology. He tended to emphasize the verbal element in communication even when addressing the issue of the use of the body as a social object. See Natanson, 1956.

[5] It is often difficult to cross disciplines due to limitations on time and familiarity with the literature. More serious problems are the differing assumptions about man and the subject matter. Despite these barriers, the literature on non-verbal communication is scattered throughout a variety of disciplines and this multidisciplinary approach is the best theoretical base at this time.

[6] Goffman often uses this approach and it is suggested as a possible methodology in Glaser and Strauss, 1967.

[7] America is not alone in its abhorrence of dirt. Body pollution has symbolic significance cross-culturally and is strongly associated with ideas of order and disorder; the sacred and the profane. See Douglas, 1966.

[8] An excellent article on the sociology of odors and their possessors was done by Largey and Watson (1972).

[9] This process is similar to that discussed by McHugh (1966). His discussion of social disintegration prior to resocialization applies here.

[10] See Fischer and Cleveland (1968) for an excellent review of the literature and statement of the problem.

REFERENCES

Barker, R. G., Wright, B. A., Myerson, L. and Gonick, M.R.
1953 Adjustment to Physical Handicap and Illness: A Survey of the Social Psychology of Physique and Disability. New York: Social Science Research Council, Bulletin 55.

Birdwhistell, R. L.
1970 Kinesics and Context: Essays on Body Motion Communication. Philadelphia: University of Pennsylvania Press.

Cooley, C. H.
1964 (c.1902) Human Nature and the Social Order. New York: Schoken Books.

Davis, F.
1962 "Deviance Disavowal: The Management of Strained Interaction by the Visibly Handicapped." Social Problems 9 (Fall): 120-132.

Deegan, M.J.
1975 "Identity Change in Modern Society. A study of the Physically Disabled." Unpublished dissertation, Department of Sociology, University of Chicago.

Deegan, M. J. and L. Nutt
1975 "The Hospital Volunteer: Lay Person in a Bureaucratic Setting." Sociology of Work and Occupations 2(November): 338-53.

Deutsch, F.
1952 "Analytic Posturology." The Psychoanalytic Quarterly 21 196-214.

Dittman, A. T.
1965 "Facial and Bodily Expression: A Study of Receptivity of Emotional Cues." Psychiatry 28(August): 239-57.

Douglas, M.
1966 Purity and Danger: An Analysis of Concepts of Pollution and Taboo. Middlesex, England: Penguin Books.

Fast, J.
1970 Body Language. New York: M. Evans

Fisher, S. and Cleveland, E.
1968 Body Image and Personality. New York: Dover Publications, Inc.

Freidson, E.
1966 "Disability as Social Deviance." in Sociology and Rehabilitation. Edited by M. B. Sussman. Washington, D.C.: American Sociological Association, Pp. 71-99.

Glaser, B. and Strauss, A.
1967 Discovery of Grounded Theory. Chicago: Aldine.

Goffman, E.
1963 Stigma. Englewood Cliffs, N.J.: Prentice-Hall, Inc.
1959 The Presentation of Self in Everyday Life. Englewood Cliffs, N.J.: Prentice Hall, Inc.

Hall, E. T.
1966 The Hidden Dimension. Garden City, N.Y.: Doubleday.
1959 The Silent Language. Garden City, N.Y.: Doubleday

Largey, G.P. and Watson, D.R.
1972 "The Sociology of Odors." American Journal of Sociology 77(May): 1021-34.

Lemert, E.
1951 Social Pathology. New York: McGraw-Hill Book Co.

McCall, G.J. and Simmons, J.L.
1966 Identities and Interactions. New York: The Free Press.

McHugh, P.
1969 "A Common-Sense Perception of Deviance." in Deviance and Respectability. Edited by J. Douglas. New York: Basic Books, Pp. 61-88.
1966 "Social Disintegration as a Requisite of Resocialization." Social Forces. 44(March): 355-63.

Mead, G.H.
1934 Mind, Self, and Society. Works of George Herbert Mead, Vol. 1. Edited and introduction by C. W. Morris. Chicago: The University of Chicago Press.

Miner, H.
1956 "Body Ritual Among the Nacirema." American Anthropologist 58: 503-7.

Natanson, M.
1956 The Social Dynamics of George Herbert Mead. Washington, D.C.: Public Affairs Press.

Ondrak, I. F.
1970 Never Give Up: Cerebral Palsy as Viewed by Its Victim. Translated by V. F. Beck and H. Jurz. Printed in Rehabilitation Literature 31 (November): 322

Scheflen, A.E.
1965 "Quasi-Courtship Behavior in Psychotherapy." Psychiatry 28 (August): 245-57.

Stone, G.P.
1962 "Appearance and the Self." in Human Behavior and Social

Processes. Edited by A.M. Rose. Boston: Houghton Miflin Co.

1959 "Clothing and Social Relations: A Study of Appearances in the Context of Community Life." Unpublished Ph.D. dissertation, University of Chicago.