SUMMARY

Society (including health professionals) ascribes inferiority to the disabled in interaction, be it consciously or unconsciously, thus further complicating a difficult new situation, physically and psychologically. Examples are cited. A plea is made for more emphasis on psychosocial rehabilitation early on.

Society determines whether some individuals should be regarded as different by selecting certain facets of their being, and attaching to these facets degrading labels and interpretations.

Example. Because you are in a wheelchair, you look different, and because you look different, I am going to HANDLE you differently.

Many times this HANDLING is by placing a person in an inferior status position: degrading him!

In many cases, ascription of difference represents a slowly developing process beginning with a traumatic experience in a person's life and resulting in hospitalisation for many months.

By repetition at every occasion of direct and indirect interaction, people weave a pattern of inferiority, ostensibly covering the whole of the individual. This may happen consciously or unconsciously. Professional people in hospital thus participate in the difference input process and mould the course of the disabled person's life.

Becoming disabled and finding oneself in a wheelchair, alters a person's life situation not only with respect to what he can or cannot do physically — which is often the major focus of the rehabilitation personnel — but also with respect to the social interaction with others.

The newly disabled person KNOWS that he is the same person that he was before the injury to his body occurred. Yet, he is so frequently and persistently placed in inferior status positions by his professional "helpers" that, in time, he is coerced into wondering if he has become a different kind of person.

The whole illness and disability experience places him in new psychological situations where his customary behaviour may stimulate responses so radically different from that he is accustomed to, that he may often, consciously or unconsciously, question who he is, what roles are appropriate for him, and what he can expect to be able to do.

The earliest and possibly the critical answers to such identity and role questions come from the hospital personnel in the everyday situations during treatment. These answers are more often subtle and nonverbal. It makes explicit the probability that the patient may have to adjust to being a second class citizen faced not only with physical obstacles, but also with social devaluation. It teaches him that as society views him, his identity and role questions come from the hospital personnel, become offended at this point, let it be understood that when the term ‘psychosocial’ is used, it does not refer to the activities and concern of any particular profession. It refers to the perception of the patient, of himself and of his immediate and extended interpersonal environment, which should be understood and responded to by all personnel, professional and non-professional alike.

The focus of rehabilitation should be to assist the patient toward reformulating a self that approves of continuing to be, the promotion of a new self-image predicated on worth, ego-integrity and self-esteem, rather than on deficiency and self-contempt.

Early rehabilitation should include facilitation of a restitutive orientation so that recrystallisation of the self is in terms of acceptance, rather than hate. The direction of this recrystallisation will be a major determinant of response to later specific rehabilitation procedures. Rejection of aids by quadriplegics well

OPSOMMING

Die gemeenskap (insluitende gesondheidspersoneel) skryf minderwaardigheid aan die gestremde toe tydens interaksie, bewustelik of onbewustelik, wat dan 'n moeilike nuwe situasie, fisies en psigologies, verder kompliseer. Voorbeelde word gegee. 'n Pleidooi word gelewer vir meer klem op vroeë psigososiale rehabilitasie.

Some common examples

- Wheeling down the corridor an attendant/nurse hustle alongside and challengingly or even sarcastically say: "Hey, where do you think you're going?" or "You're not supposed to be here — go to your room."
- Getting your wheelchair hijacked by somebody without comment, and being wheeled to the dining-room.
- Staff meetings, where the patient is supposed to participate in his rehabilitation, are held without him.
- When patients enquire about why some therapeutic procedure is being employed, it is not uncommon for them to be told: "It is good for you" or "Doctor's orders."

Perhaps the most common way of telling the patient that he is a machine in the shop for repair is the habit of communicating with the person pushing the wheelchair, instead of with the patient himself. The patient finds himself sandwiched between two white coats with the one asking the other: "Now where does she go?" It can be asserted that the job of proper rehabilitation of patients is impossible without giving full cognizance to the impelling psychosocial problems that they face.

It is regrettable that treatment of persons with such conditions should have become fixed within an essentially medical, rather than a more general rehabilitative mode because, except for the initial period and for the subsequent maintenance of good physical health, the predominant problems are:

- emotional
- interpersonal
- functional
- vocational

AND in that order!

Now, lest physicians and other medical persons directly involved, become offended at this point, let it be understood that when the term ‘psychosocial’ is used, it does not refer to the activities and concern of any particular profession. It refers to the perception of the patient, of himself and of his immediate and extended interpersonal environment, which should be understood and responded to by all personnel, professional and non-professional alike.

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TO BE DIFFERENT

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The authors set out to investigate the psychological problems involved in adjusting to paraplegia. The purpose of the study was to serve as a guide for physiotherapists.

Personal interviews based upon a questionnaire were conducted with 14 paraplegics. The sample group ranged from 14 - 61 years of age. There were 9 males and 5 females. At the time of interview the duration of disability ranged from 5 months - 20 years.

Results showed that 85% of patients interviewed regarded physiotherapy as essential. However, certain areas of need were highlighted. These include well-defined goals and ongoing explanation of the implications of paraplegia. Interviews revealed what paraplegics considered their worst experiences. These include:

- The first realization of the prognosis (43%).
- The inability to control bladder and bowel (29%).
- Feelings of clumsiness, awkwardness and ugliness associated with their first time in a wheelchair.

Physical strengthening through therapy and a close relationship with the physiotherapist were very encouraging aspects of physiotherapy. Discouraging aspects included boredom at the repetition of treatment and the slow progress in rehabilitation.

Patients were asked what advice they would like to give to physiotherapists. Answers were mostly related to the relationship between patient and physiotherapist. It was felt that the physiotherapist should take time to understand her patients, give them confidence and know you’ll walk again. When treating the patient experiencing denial, it is important that the physiotherapist give the depressed patient hope by, e.g., attaining a goal in physical rehabilitation to help relieve some despondency due to increasing independence.

- Defence mechanisms used by paraplegics. Denial, which is commonly noticed, may be reinforced by sensory changes and muscle spasm in the paralysed parts of the body. The attitudes of others may also reinforce denial as portrayed in the following typical comment: "We’re praying for you and know you’ll walk again.” When treating the patient experiencing denial, it is important that the physiotherapist does not try to convince the patient of reality but works with denial and helps the patient to make the most of the present situation by encouraging participation in rehabilitation. A defence mechanism cannot be discarded until the individual is strong enough to cope with reality.

Bibliography
