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 regarding 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:

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The fear is that the emphasis on function serves as a ready way of avoiding the affective implications of disablement.

This year is the INTERNATIONAL YEAR OF DISABLED PERSONS (and I put the emphasis on persons) and now is the time to put things right in your own mind and also in the so-called rehabilitation centres.

I did not choose the topic of the attitude of the public towards disabled persons because I firmly believe that once a disabled person has learned that his disability is irrelevant for the attainment of some of his more basic goals, he will find the attitude of the public not such a great obstacle.

Bibliography

ROSEMARY WOOD, BSc (Physio) U.C.T., JENNIFER BARRETT, BSc (Physio) U.C.T.

The psychological aspects of paraplegia: a guide to physiotherapists

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In many cases time is the great healer. Other defense mechanisms include: withdrawal, projection, identification, rationalisation.

In conclusion, the importance of a personalised relationship between therapist and patient must be stressed. The physiotherapist must understand the personality and emotional type of the patient she is treating, thus enabling her to treat the whole person.

A relationship based upon openness, give and take, mutual trust and empathy will help the paraplegic appreciate his own self worth as a unique human being. Intuition and experience are not sufficient in understanding our patients fully. A knowledge of psychology must be an integral part of the physiotherapist's skills. It is therefore essential that psychology be included in the education of all physiotherapists.

MANAGEMENT OF THE SEVERELY DISABLED

REPORT OF A SYMPOSIUM HELD IN APRIL 1981

A one-day symposium on the Management of the Disabled was arranged by the Department of Physiotherapy, University of Cape Town (U.C.T.) in conjunction with the Post Graduate Medical Centre, as part of the activities of the International Year for the Disabled. During the morning session several professionals gave an outline of the respective roles in handling the disabled and a patient also put his point of view. In the afternoon session specific problems of a selected number of disabilities/diseases were discussed. Abstracts or full papers were made available to all participants (over 80 of all disciplines), and adequate time was allowed for discussion.

Professor George Watermeyer of the Department of Community Health, U.C.T., set the scene by discussing the Philosophy of Rehabilitation in 1981 and stated that rehabilitation is a concept whose meaning varies from the precise to the vague, according to individual taste, practice and experience. Quoting A. Mair, traditionally rehabilitation was restricted to physiological methods applied to local parts of the organism, designed to improve function and alleviate symptoms. This had to be re-defined since the definition of the healthy state has become much wider and now encompasses a state of positive physical, psychological and social well-being. Many attempts, however, have become bound by the discipline they represent and end up with Mair's definition. More note should be taken of mental and social factors which may be more crippling than the obvious physical component, whilst cultural and environmental factors, totally amenable to correction, may compound a disability and enhance dependence. He cited the example of the amputee, "fully rehabilitated"; that is discharged home and then becomes homebound, isolated and depressed because a sandy sidewalk prevents him from getting his wheelchair out of the house; similarly, disrupted family relationships, cross-cultural constraints and other social issues may modify the outcome of an otherwise well-intentioned and carefully designed rehabilitation programme. The process of rehabilitation does not have a certain starting point and an end point in the course of disease/disability; however, periods of optimal intervention and times of maximum effect must be identified and utilised maximally for each individual circumstance. Rehabilitation goals should be realistic both for the patient and the therapist and sufficient time devoted to the assessment of progress. Evoking false hopes and expectations often result in a loss of confidence and compliance, thus it is important to state an acceptable goal and adhere to it. Assessment of the residual ability should not only be of physical and mental capability, but include the family, social, cultural and community resource potentials.

Active rehabilitation, be it complex and multifaceted, occupies a relatively short period and then the real problems start. Long-term support of the disabled in the community is essential. The concept of "alleviate care" put forward by Abel-Smith, namely that a community health care facility can care for the chronically ill within the community and that facilities can be mobilised in the community to help ease the burden of the care required by disabled at home, seems ideal. It would thus seem that the responsibility for rehabilitation and after-care of the chronically ill/disabled should be accepted by both health professionals and the community alike and we would be nearer to the ideal of broad definition as stated by Mair. In South Africa the acceptance of the concept of rehabilitation by professional bodies has been slow, fragmented and unco-ordinated but the Health Act of 1977 has laid the ground rules for a total strategy which aims at a comprehensive, multi-disciplinary approach to long-term care of persons with chronic disabilities.

Miss Ida Bromley, Superintendent Physiotherapist of the Royal Free Hospital and District Physiotherapist of Camden, as well as Chairman of the Council of the C.S.P., addressed herself to the role of the physiotherapist and titled her paper "Observation + Action = Prevention". A trial document, the International Classification of Impairment Disabilities and Handicaps, published by the World Health Organization in 1980 with the subtitle A Manual of Classification Relating to the Consequences of Disease, attempts to give guidelines to assess and classify disablement sothat information can be gathered on a sound basis and a better understanding of the problems can be obtained. In developed countries chronic illness and medical responses to it occupy a dominant position and more attention needs to be focussed on the disabling and handicapping consequences of disease rather than the pathology. She went on to define common terms; impairment is any loss or abnormality of psychological, physiological or anatomical structure or function; disability is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for human beings; handicap is a disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfilment of a role that is normal (depending on age, sex, social and cultural factors) for that individual. Handicap thus occurs when there is interference with the ability to sustain what the C.S.P., addressed herself to the role of the physiotherapist and titled her paper "Observation + Action = Prevention". A trial document, the International Classification of Impairment Disabilities and Handicaps, published by the World Health Organization in 1980 with the subtitle A Manual of Classification Relating to the Consequences of Disease, attempts to give guidelines to assess and classify disablement so that information can be gathered on a sound basis and a better understanding of the problems can be obtained. In developed countries chronic illness and medical responses to it occupy a dominant position and more attention needs to be focussed on the disabling and handicapping consequences of disease rather than the pathology. She went on to define common terms; impairment is any loss or abnormality of psychological, physiological or anatomical structure or function; disability is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for human beings; handicap is a disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfilment of a role that is normal (depending on age, sex, social and cultural factors) for that individual. Handicap thus occurs when there is interference with the ability to sustain what the C.S.P., addressed herself to the role of the physiotherapist and titled her paper "Observation + Action = Prevention". A trial document, the International Classification of Impairment Disabilities and Handicaps, published by the World Health Organization in 1980 with the subtitle A Manual of Classification Relating to the Consequences of Disease, attempts to give guidelines to assess and classify disablement so that information can be gathered on a sound basis and a better understanding of the problems can be obtained. In developed countries chronic illness and medical responses to it occupy a dominant position and more attention needs to be focussed on the disabling and handicapping consequences of disease rather than the pathology. She went on to define common terms; impairment is any loss or abnormality of psychological, physiological or anatomical structure or function; disability is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for human beings; handicap is a disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfilment of a role that is normal (depending on age, sex, social and cultural factors) for that individual. Handicap thus occurs when there is interference with the ability to sustain what might be described as "survival roles". Describing the consequences of disease more accurately and categorically will clarify the issues and give less offence through inadvertent stigmatising of people who have disabilities or handicaps. She cited the example from the Norwegian poet Bekke: "I used to be Mrs. Lind with a stiff hip. Now I am a stiff hip called Mrs. Lind." Handicap or disadvantage resulting from a patient's impairment may be increased through in-