HUFFPOST HEALTHY LIVING

Michael Friedman, L.M.S.W.

Adjunct Associate Professor, Columbia University Schools of Social Work and Public Health

Meeting the Emotional Challenges of Acute Inpatient Rehabilitation

Posted: 02/25/2013 4:28 pm

(This is the second part of a two-part post on my experience in rehabilitation.)

In my previous post, I described the emotional challenges that I and probably most others experience when they go into acute inpatient rehabilitation. These include distress about dependency and about loss of personal privacy, dignity, and autonomy. The challenges also include coming to terms with a realistic assessment of how long it will take to recover and, for some people, the likelihood of permanent disability. Tough stuff, but, according to staff I talked with, most patients deal with these emotional challenges and get focused on the work of rehabilitation and recovery in three to four days.

How does this happen? How are patients helped to avoid sliding into demoralization, depression, and dysfunctional distress?

I can speak only about my experience at Burke Rehabilitation Center, an absolutely wonderful acute inpatient rehabilitation facility in White Plains, N.Y. There, the most striking factor is the humanity and professionalism of the staff. The nurses and nursing assistants were remarkably sensitive to my wanting to do as much as I possibly could for myself but gracious about providing help as frequently as I needed it. They were also sensitive to my discomfort about being naked and going to the bathroom in front of them, giving me as much privacy as possible without jeopardizing my safety. They handled toileting, washing, and dressing in a matter-of-fact manner that created an atmosphere in which getting help with these things as an adult was the norm rather than a source of humiliation. At the same time, they appreciated the humor of the situation, or at least they laughed when I joked about it.

In addition, the physicians and other health professionals included me in the process of making medical and other plans. I felt I was not just a patient taking orders from a health care provider on high but a respected part of the health care team.

Staff also talked with me as one human being to another, answering my questions about where they lived, where they came from, whether they were married, had children, and so forth. They asked me similar questions. So, while preserving appropriate boundaries, we got to know each other a bit, rather than my being just a patient and their being total strangers. It made a great difference.

The physical therapists and occupational therapists who helped me were also friendly, engaging, knowledgeable, and matter of fact. And they got right down to business.

At my first regular meeting with the young woman who would be my occupational therapist for two weeks, I got a lesson on dressing using assistive devices, learned how to get into and out of a stall shower using grab bars to prevent falling, and more. We talked about what equipment I would need at home to be able to use the toilet, shower, and get around without tripping. In short, the work of rehabilitation started immediately.

Then I went to physical therapy for the first time. As I walked with the support of the physical therapist, she pointed out to me that my feet wandered into each other both because my legs were weak and because I was not able to feel the location of my left foot. She defined several tasks for me -- to watch my feet and keep them apart while I walked, to learn to move my legs up and down without flopping from side-to-side, and more. Here too the work of rehabilitation began immediately.

This process of identifying small goals and celebrating small achievements was, I think, key to my being able to remain hopeful without losing sight of the reality of my condition. The staff helped me to recognize each day's achievements and to celebrate them. So I remember clearly the day I moved from taking halting steps -- left drag up the right, left drag up the right -- to putting one foot in front of another. Wow! Or moving from my left foot flopping to the side like a dead fish when I lay on my back to being able to point it up, to being able to move it while it was pointing up, etc. Each day brought small victories that fueled a sense of achievement today and a sense of hope for tomorrow.

Developing basic skills and learning to walk on a walker became my job. This was the fundamental expectation of the facility. We were there to work. This attitude was a huge help to me, not only for keeping me focused on rehabilitation but for my fundamental attitude about myself. I was not a dependent and passive slug. I was a person who could take action to improve my condition. I had much more control than I felt when I first arrived.

I can only imagine how depressed I would have become without my job. I have often written and lectured about depression, and I always point out that the two best antidotes to depression are being active and being with people. The rehabilitation facility made both possible. The expected work in physical and occupational therapy provides plenty to do. And, because occupational and physical therapy are done alongside others, there is a lot of opportunity for socializing. Pleasant chit chat is the expectation. When we were together waiting for the elevators or for class to start, we asked and answered a standard litany of questions. What are you in for? Do you have a discharge date? What do you think of the food? Where do you live? Will someone be at home to help you when you leave? And then chatter about children, jobs, etc. We talked about our pain

sometimes, but the focus was always on how we dealt with it, not on how awful it could be. In some ways, it was like being on a cruise. Lots of superficial interactions while avoiding talk of politics, religion, and personal tragedies. All of this, I am convinced, helped to keep our fears and sorrows at bay.

I am a mental health professional, and before my personal experience I would have thought that counseling and/or formal mental health services would be important to help people through the emotional turmoil of inpatient rehabilitation. No doubt some people become clinically depressed in these circumstances and need treatment. But, for most people, the emotional turmoil of the first couple of days is not mental illness. It's a normal, expectable response to a distressing situation. And it seems to me that basic humanity and what is now called "patient-centered care" are what facilitate the psychological adaptation that is critical for effective physical rehabilitation.

It is quite remarkable.

For more by Michael Friedman, L.M.S.W., click here.