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DEPRESSION AND PHYSICAL REHABILITATION

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Abstract

Depression is often expected in our society during physical rehabilitation. This and similar expectations structure the experience of a physical disability. Contradictions in expectations and demands by providers to conform to this paradigm create barriers in the rehabilitation process. Changes in the physical rehabilitation paradigm are briefly suggested.

DEPRESSION AND PHYSICAL REHABILITATION

In our society depression is expected to follow after a traumatic permanent physical disability (Kerr-Cohn, 1961; Fink, 1967), and it is felt to be a result of concrete losses of body functions and skills. This state often initiates changes in one's self-image, social position, and interpersonal relationships (Barker, *et al.*, 1953; Wright, 1961; Goffman, 1963). It is suggested here that depression is a response which emerges not only from the individual and his perception of the situation, but also as a function of the physical rehabilitation process itself. The source of the depression is a result of the contradictory assumptions and goals inherent in rehabilitation, and as a result depression is expected and maintained by this approach.

This type of depression can be traced directly to a social construction of reality (Berger and Luckmann, 1966) that is rarely articulated because of its fusion with the more concrete and localized depression following loss. Examining this system of logic, the therapeutic model, will hopefully open up this subject for discussion in order to minimize the man-made suffering which is presently considered inevitable.

THE GOALS OF PHYSICAL REHABILITATION

The system of logic underlying the present approach to physical rehabilitation can be stated as follows:

The disabled person is invested with a status and dignity which is inherent in all human beings. He, unfortunately, has suffered a loss as a result of a physical limitation which may

affect other social and psychological areas of his life. He will usually be depressed soon after incurring this loss but he will hopefully learn to accept and/or cope with this after an appropriate period of mourning.

These losses should be minimized so that he can continue in his life as "normal" as possible. A major goal is to participate in the labor market and economy and earn his daily living rather than be supported by others. This is a method for him to be independent, self-sufficient, and worthy of respect.

If the reader doubts the validity of this model, a series of quotes by leaders in the field of physical rehabilitation should support the above contentions:

A facet of vigorous individualism in American culture tends to support activities such as health services which enhance the worth and dignity of the person, especially if these lead to increased social and economic effectiveness. (Rabbinowitz and Mitsos, 1966:2)

(A psychologist states:) "Most people are motivated for health. The handicapped want to be well and normal, considered the same as others; most have a capacity for self-sufficiency when allowed to act for themselves." (Quoted by Alexander, 1970).

(An orthopedic surgeon states:) ...that normal people must let handicapped people do what they can for themselves.

"They will then feel part of the world.... It helps the handicapped to feel respect for themselves, to have dignity." (Alexander, 1970.)

(Vice-president and medical director of a rehabilitation hospital)

"The hospital's goal is to return every patient to his family, his community, and, most important, his job." (Quoted by Mateja, 1974)

The contradictory and illogical arguments of this approach become apparent when each assumption about disability and rehabilitation is examined in a total context.

A person is inherently worthy of respect yet he must "earn" it through achievement and activity (which he may physically be unable to do). He does not want help from others in order to be independent, yet

he must learn to "accept" his dependence. He has undergone a significant personal loss, therefore, he should be depressed. But he should be depressed "correctly": he should not be over-depressed nor under-depressed. Over-depression occurs when the depression takes a course which interferes with institutional demands and expectations. Under-depression occurs when the person is "denying" reality and/or too readily accepts the disabled status. An example of "under-depression" is given by Israel Goldiamond, a professor at the University of Chicago who specializes in behavior modification and is also a paraplegic. Since he believes that behavior is affected by contingencies and not by emotions, he "refused" to be depressed. When he began suffering from insomnia, the staff told him that, of course, his depression was finding a way to exhibit itself. Due to his habit of keeping records on his medication, he discovered that he had taken himself off tranquilizers and was suffering from withdrawal effects, a fact which had been overlooked in the eagerness of the staff to reinforce their expectations of his disability. (Goldiamond, 1976.)

Physical therapy is a painful, grueling process that is based on the strengthening and maximal use of a person's muscles and physical skills. To endure this training for an often very small change in one's physical functioning is discouraging. The right to decide if one wants to do that much work for that small a reward is often denied the disabled person. Rather he is bullied, told that he must do this for his own good, and told to be motivated for something that may be largely lost. Defeats for physical therapists can be daily comforts for the disabled. An example of the right to decide certain treatments and aides is presented by Ed Roberts, a spokesperson for Berkeley's Center for Independent Living.

"Health professionals go through these incredible fads... For example, they were convinced that using an iron lung was a terrible thing and should be stopped as soon as possible, almost at any cost. Well, I say that's up to me to decide. If not using the tank means I'm going to have something less comfortable and less ventilating, if it means I've got to spend more time concentrating on just breathing, then I'll use the tank." (Quoted by Downey, 1975:25)

The individual in a rehabilitation setting, then, is told that he is not physically "normal" and that he should learn to accept his losses and try to re-enter "normal" life.

One nurse who is a paraplegic responded to this definition of the situation in this way:

After much thought I began to understand why I felt insulted and angry at the request to "accept your disability." Acceptance implies the result of a choice with the option to refuse. We are not injured or diseased and handicapped by choice. Why should we be made to feel obligated to "accept"? (Jones, 1972)

The emphasis on vocational skills and contributions of the physically handicapped has been emphasized since the beginning of the vocational rehabilitation movement in this country in 1920 (Strauss, 1966). It is the method that the governmental agency uses to get funds for rehabilitation training and programs. In this arena there is little attempt to say that this is a worthwhile human endeavor, but rather that this is a profitable venture. One recent article extolling the virtues of providing training and employment for quadriplegics showed the financial benefits of this plan:

For example, Client #4 became disabled at age 18 due to a diving accident and was referred to the Department of Rehabilitation. In approximately 7 years the department spent \$10,737 towards his rehabilitation. Projecting additional services through 1973, when he would obtain a Master's degree, the total case cost will approximate \$20,000. Since welfare costs without successful rehabilitation would amount to almost \$6,000 a year, this client, when rehabilitated and no longer receiving welfare, will offset his rehabilitation costs by welfare savings in 3 years and 2 months. (Savino, Belchick, and Breaun, 1971:9)

The continual dialectic between inherently worthy and the necessity of proving it through achievement and mastery of one's environment is a basically unresolvable struggle. This becomes more acute when considered in light of support for changing one's values.

For applying to himself the standard of the "normal" the disabled person feels that his inability to achieve implies that he is unworthy. The energy and effort expended in the direction of overcoming the disability, reaching the non-injured standards, are dissipated as the C.V.A. (Cerebral vascular accident) realizes the hopelessness of the task. (Schlesinger, 1965)

This analysis of contradictions which push towards independence and self-sufficiency when the person is often unable to be either, and the advice to accept something which prevents him from wanting to participate

in painful therapies and changes while extolling the virtues of acquiring and simultaneously fighting creates an impossible system of adult socialization (Cogswell, 1967).

SURVIVING THE SYSTEM

Examining this construction of reality, the reader can sympathize and recognize the "truth" that a physical disability is a tragedy. It has often been suggested that the courage and heroic manner of the physically disabled arises from their confrontation with this eternal human dilemma and their ability to surmount such contradictions. But perhaps part of the "truth" arises from the definition of the situation and not from the situation itself. It is suggested here that disability is seen so negatively and of such drastic import because the philosophy and logic has been derived and maintained by the non-handicapped. A special subgroup of this "rehabilitation" world includes the professionals who are often trained in psychological and psychoanalytical concepts and dynamics. Their world-view emphasizes the fear of mutilation and castration which are symbolically related to physical disabilities (Blood and Ventur, 1963.)

It is suggested that the "adjustment" to a handicap could be less "super-human" and extraordinary if the system of logic were altered. (See Wright, 1960, for a discussion of this problem which sets the disabled apart from others, especially pp. 57-58.) Although it is impossible to establish a "right" value system, it is possible to see the alternate views held by the disabled and others in our society whose definitions of the situation challenge that presented above,

CONTROL OF CONTINGENCIES AND PERSONAL REWARDS

Goldiamond (1976) wrote of his own approach to disability using the behavior modification approach:

...emotions do not cause behavior, rather, emotions and behavior are governed by contingencies. (p.7)

And the existence of such a contingency relation or its absence was what, from my observation, distinguished those patients whom the staff described as "unmotivated" or "impossible to reach" or, in less charitable moments, as goof-offs. (P.8)

Many patients feel helpless and dependent because they are. They are given medicines which may change their behavior or moods. They are forced into regimens which are tightly timed and controlled by "experts."

They are removed from their everyday world and its supportive friendships and familiarity. In general, they are being manipulated at a very high personal and financial cost. Use of Skinner's "technology of behavior" may be an improvement in man's right to choose his path to "freedom and dignity" (1971). Although there are many possible errors in this approach by another "expert" it does suggest the possibility of setting up alternate institutional structures to serve people who want medical help without the system of logic proposed here.

BELIEF IN AND SUPPORT OF A DIFFERENT TYPE OF ECONOMIC SYSTEM

Efforts to demand health care as a human right are becoming more widespread. An extension of these demands is the right to a more equal share in the total wealth of a system either through communism or socialism. The present emphasis on work is not only a strain for many disabled because of their limited skills but also because of the discrimination which they face on the job market--which is particularly depressed at present. Rather than continue to fight for meager opportunities and rejection, some people start to reject this system of economics.

REJECTION OF THE WORK ETHIC

With rising expectations of what a job should be like, and questioning the validity of it as a measure of self worth, the "Protestant Ethic" is shaky (Weber, 1958). Efforts to rehabilitate a person for a "workshop" or sheltered care facility are likely to be met with increasing resistance. As one amputee expresses it:

"I lost my legs--I didn't lose my mind. Don't offer to set me up in my apartment with a telephone answering service. You've got to come up with a better answer than that if I've got a trained mind. Don't try to get me to lace leather thongs into baby shoes if I can play a musical instrument, write a book, work toward a college degree, or create anything at all." (Quoted in article, The Star, Oct. 10, 1973)

If medical care is contingent upon the type of institution one enters and the subsequent quality of care one receives--which it is--then those patients who do not share in the "logic" of rehabilitation are likely to receive fewer options and have fewer rights. The process of considering the re-structuring of the programs is beginning to be considered by some:

The counselor must be prepared to deal with a client who demands a self-actualizing occupation or a job-enriched placement, even if such jobs are not available. Such demands

are not necessarily an excuse for not working. They belong to a new work ethic which the disabled are as much entitled to hold as the non-disabled... Young or disadvantaged clients in particular may be more "choosy" than before, but middle-aged workers could also absorb the new ethic from their children or from fellow workers, or from the public discussion of the work ethic.

Then there will be those whom the "secular religion of work" has never touched who may find welfare, institutionalization, or crime as a means of survival. (Gilbert, 1973: 16-17)

THE BENEFITS OF BEING DISABLED

This last change in definitions of the situation of disability is purposefully left at the end of the argument. The belief in the negative aspects of disability has become so ingrained in our society that it appears impossible to tamper with this "universal truth". This firm assumption that disability is bad, evil, and terrifying can be compared to our response to death which is also being challenged now. Rather than give an analytic discussion, a lengthy quotation by Ed Roberts is included as a presentation of this more favorable approach and empathetic understanding of a disability:

"By saying I enjoy being disabled, I guess I'm trying to counter the negative image of what we are. It's like when we call each other 'crips' or cripples. That's a word like 'nigger' and it's about time to take the sting out of words like that. There are really benefits to being disabled, though. There's the very fact that you've come through a severe trauma. For many, our disabilities have made us very strong. By overcoming tremendous physical inconveniences, whether you're born with them or not, you can gain a real pride in yourself. It's one way to achieve the thing that many people strive for--an inner peace." (Quoted by Downey, 1975:25)

Further programs of action and entry--real entry, not toleration--are being established and/or fought for by militant disabled groups across the country: demands for reduction of architectural barriers, financial aid for education, vocational training, and placement; communal living facilities rather than isolated, institutional settings staffed by impersonal professionals "helping" a fragmented group of inmates, and acceptance of the disabled as people who demand equal treatment and status in society. A greater control of the hospital and re-

habilitation care system are being demanded as they are being demanded by other neglected consumer groups. All of these mechanisms to change the social structure and definitions of reality are seen as possible methods for reducing "depression" in the physically handicapped. This would therefore substitute a model of social change rather than psychological change as a means of adapting to traumatic physical injuries.

CONCLUSION

This paper has examined the system of logic supporting a massive industry of physical rehabilitation which affects a large number of people in our society. It has attempted to show, among other things, that applied sociology and the examination of our society within a phenomenological framework can be mutually compatible.

It also illustrates a potentially new definition of reality which is emerging from a group which is structurally and socially marginal in our society. This would be expected from a theoretical understanding of the situation; i.e., their lack of integration into society makes it easier to experience and recognize dysfunctional aspects, but it appears to the author that the establishment of the rehabilitation system was a necessary prerequisite for the development of the consciousness of the disabled as an oppressed group. The presence of other protesting groups such as blacks, chicanos, women, and American Indians also served to create an environment favorable to challenging the social structure and established definitions of it. In addition, the phenomenon of rising expectations made possible through better care and therapies may have brought to light the large discrepancies between what could be possible and what actually was occurring. It is always ironic that improvements in the system increase attacks on it emphasizing the need for reform.

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