Clinical Prosthetics and Orthotics, Vol. 10, No. 2, pp. 55–56

Rehabilitation: Goals or Shoals?

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In the pre-1960 period, the dominant aim of rehabilitation personnel working with amputees was the restoration of the amputee to maximum pre-morbid functioning. Lower-extremity amputees had little choice. A degree of prosthetic restoration consonant with some ambulation was necessary in order to provide some independence and self-sufficiency. Upper-extremity amputees were also presented with the goal of maximum functional restoration. While comfort and cosmesis were given their due, the explicit dogma was restoration to as much premorbid functioning as was mechanically feasible. The writer remembers the dictum of one expert, "a hook for work and a functional, cosmetically acceptable hand for recreation." An upper-extremity amputee might plead that he had learned to "manage" with his intact hand and was, therefore, interested only in an acceptable, passive appendage to fill a sleeve and allow him to mix in society inconspicuously. All in vain. He was regarded virtually as a self-denigrating quitter who was undermining his own livelihood, as well as a heretic in our work ethic society. To an appreciable extent this pejorative judgment was then true because in the pre-60's period there were, as yet, no "Great Society" programs which were to introduce alternative means of financial support. To a worker in the pre-60's period, functional restoration was the life raft which prevented him from sinking unless he was content to gasp through life on the dole and undergo the psychological angina pains of conscience.

When the "Great Society" programs were introduced, the work ethic, for better or worse, was to a considerable extent attenuated. Moreover, improvements in technology, reduction in the need for manual labor, and the proliferation of new types of jobs allowed amputees better viability because an entirely intact body was no longer necessary for self-support. Yet the dogma of total, functional restoration hovered in the consciousness of rehabilitation personnel. While society in the 60's became more interested in immediate self-gratification, rehabilitation experts, who had been trained to make men and things "work," retained their pure work ethic consciousness. Physicians desired that body functioning become normal; physical and occupational therapists knew that somatic improvement required vigorous exercise; psychologists believed in maximum self-realization; and engineers and prosthetists yearned for more powerful mechanisms to provide normality. The old-fashioned work ethic had, to a considerable extent, been replaced by a new pay ethic—more pay for less work and poorer service for higher fares. We rehabilitation workers, however, remained aloof on Mt. Sinai, in our pristine innocence, proclaiming the Ten Commandments to stiff-necked and stiff-limbed rehabilitants who preferred to dance around the golden calf of entitlements.

While recent political changes are striving to restore the work ethic to its former glory, the average person does not readily relinquish the desire to be presented with a set of options from which to choose. Attempts to enforce one set of standards or goals equally on all rehabilitants are doomed to fail.

Perhaps some examples of individual person-

ality types I have encountered among amputees seen at NYU Medical Center and in private practice will illustrate the distinctive rehabilitation goals of different people.

CASE STUDIES

"A" applied as a volunteer experimental prosthesis wearer. He had lost his non-dominant hand in an accident. During the interview, he impressed the writer with his stability. His psychological test profile was exceptional. The writer remembered "A's" well-executed and orderly Bender-Gestalt drawings and recommended him for a position at an agency where he is still employed. I never saw "A" wear anything but a hook when I visited the agency. He never attempted to emphasize his functional restoration goal. His good-natured and efficient performance with his hook spoke for itself. In my conversations with him on various topics, both vocational and personal, he would often become enthusiastic and wave his hook in front of my eyes to emphasize a point. I never "saw" the hook. His efficiency and personality preempted his amputation. All I saw was the person, not the disability.

"B" was a double hand amputee volunteer. He was gainfully employed and wished to contribute to amputee rehabilitation. "B" underscored his conviction of absolute normality. He wished to demonstrate this to the staff by maneuvering his two prostheses and a sheet of paper to pick up a dime. He failed a number of times before succeeding, but the note of triumph in his eye compensated for the failures. "B" had convinced himself that he was normal and who were we to question him? He was gainfully employed, easy to deal with, and adjusted to his environment. His "super normality" was irrelevant since this illusion did not interfere with his various roles as a human being.

"C" did not require functional restoration for his work. He wore an active, cosmetic hand because of his desire not to attract attention to his disability, and his prosthesis was useful for minor tasks. He refused to wear a hook for more inclusive manual functioning. His goal was mainly cosmetic. The limited function of the type of prosthetic hand then available was satisfactory to him.

"D" wore a passive hand with no function. His main goal was to appear normal to the casual observer. To some work ethicists on our staff "D" was regarded as an unactualized individual, but "D's" goals were not the attainment of complete self-actualization, but merely a wish to blend with the crowds on the trains and street.

"E" was a prosthesis wearer interviewed for phantom limb experience. Our explanation as to the potential value of the study was misinterpreted by him. He somehow gained the impression that further knowledge about phantom limb sensation and neurological functioning would enable scientists to grow a new, natural limb on his amputation stump (as is the case with some lower animals). He nervously inquired "Will I lose my pension?" This veteran was so satisfied with his prosthesis (and disability pension) that he seemingly rejected the ultimate restoration, a reborn limb!

"F" lost his left hand in an accident. He absolutely refused to wear his prosthesis because of discomfort and because he functioned adequately with his intact limb. His empty sleeve was virtually "filled" by his outgoing and warm personality. His interpersonal behavior was the best camouflage for his amputation. He was an amputee who had the best prosthesis of all—his total personality. Unfortunately, he later died, following a disease unrelated to his amputation. The large funeral chapel was packed with people from numerous walks of life.

Each of these individuals represents a different personality type with distinctly different goals and levels of achievement, satisfactory to each if not to rehabilitation personnel.

My experience as a psychologist has convinced me that different patients are ready for varying levels of growth. Some patients who have made appreciable, but not optimal gains in psychotherapy will leave. A percentage of these will return months or years later, after they have assimilated their original gains, to strive for a higher level of achievement. The choice must be voluntary.

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