Rehabilitation as a movement has grown out of the needs of disabled persons, which are different from those of the sick. Rehabilitation is developing into an holistic concept, which focuses on the whole person, not just on his or her physical or mental handicap. An holistic approach towards disabled persons and their rehabilitation is based on an awareness of the functional interdependence of psychological, physical, social and vocational factors in human health, illness and recovery.

The physical, functional, psychological and social impact, which a stroke can have on a person, is described to illustrate the complexity of the disabling process, and the need for all rehabilitation team members to share holistic goals.

The benefits of rehabilitation are maximized by an holistic approach, which aims at enabling persons with disabilities to function in society to the fullest physical, mental, social and vocational usefulness of which they are capable.

Historically, it was first the needs of crippled children and then the flood of disabled veterans from the world wars that gave impetus to the rehabilitation movement (Wessen 1965). Rehabilitation units have been established because disabled persons have different needs from those of the sick. In place of the classical emphasis on disease, diagnosis and therapeutic procedure, the rehabilitation model stresses restoration of normal function, adjustment and retraining (Wessen 1965).

Rehabilitation therefore defines patients not as passive recipients of care, but as persons whose motivation to master their handicaps must be enlisted, in what is a joint endeavour of disabled persons, families and professionals. The task of rehabilitation is to restore disabled persons to the fullest physical, mental, social and vocational usefulness of which they are capable.

As a philosophy, rehabilitation is holistic in character because it is based on awareness of the functional interdependence of physical, psychological, social and vocational components in human health, illness and recovery. Holistic rehabilitation necessarily focuses on the whole person, not just on his or her physical or mental handicap. Rehabilitation, as an holistic concept, crosses traditional interdisciplinary boundaries, and this has necessitated the evolution of the multidisciplinary team. Teamwork involves a significant levelling of professional status distinctions and joint decision making, which contrasts with the traditional hospital type organization of health professionals working under the direction of a doctor. In practice, these teams have encountered difficulties because professionals were often operating on individually defined, professionally based goals, which were not coordinated with each other. As a result, disabled persons were often presented with conflicting ideas and approaches towards their disability and rehabilitation. It is not adequate for each team member to do his or her job with each person on a one-to-one basis; all the efforts must be coordinated and integrated within an overall framework. The professionals in a team need to share a common approach in working towards a common goal, for the benefits of their efforts to be maximized. With an holistic approach towards each disabled person and towards the concept of rehabilitation, the team is working as a whole to rehabilitate each person as a whole.

One needs to understand the disabling process itself before attempting to prevent or reverse its progress in rehabilitation. A description of the impact stroke has on a person's life physically, psychologically and socially will illustrate the interdependence of these factors in disability and the need for an holistic approach towards them, in rehabilitation.

Physical and functional problems

A stroke can leave a person with the sudden onset of symptoms such as incontinence, abnormal tone, defective sensation, problems of movement, difficulties with speech and mental confusion. These symptoms have a far-reaching impact on the person's future functional abilities in caring for himself or herself, in getting around and in working, whether at home or in the workforce. The rehabilitation team is responsible for encouraging the fullest participation of the disabled person and family in re-learning motor skills and in working towards being as independent as possible. Members...
of the team need to be aware of their individual responsibilities so that cooperative relationships can be established throughout the team.

The physiotherapist's responsibility in rehabilitation is to enable persons to regain motor skills, particularly with regard to everyday activities (Shepherd 1979). Physiotherapy treatment should be shaped by the disabled person's needs and wants within a broader holistic rehabilitation framework, which acknowledges the interdependence of psychological and social factors with physical and functional recovery in rehabilitation. Because of this interdependence, nurses, doctors and other therapists in the team need to be aware of the bases of physiotherapy treatment and have some understanding of muscle tone and the importance of sensory feedback in re-learning motor skills (Carr and Shepherd 1976). At the same time the physiotherapists must be aware that the person is in the company of family, friends and fellow team members for at least 22 hours of the day. Therefore, if the physiotherapist is teaching a person to walk with a more normal gait, for example, every team member should be able to reinforce the correct walking pattern in the course of their contacts with the person, so that he or she is given consistent and appropriate encouragement. For example, the physiotherapist might be encouraging a person to walk unaided in treatment, the benefits of which are counteracted if the nursing staff and person's family are encouraging the person to use a quad stick. On the other hand, the physiotherapist's treatment should be coordinated with that of the doctors, social worker, occupational therapist, speech therapist and nurses. Functional rehabilitation prospects are maximized when the disabled persons and their families are guided by professionals who share an holistic approach towards them and their rehabilitation.

Psychological reaction

Rehabilitation team members need to be aware of the psychological reaction that follows the onset of a disabling condition. In particular, they should understand the characteristic train of events, known as the 'grief reaction', which occurs with bereavement or with injury or disease, as a result of disruption of life and all that this means in loss of abilities, self-esteem and status (Hetzal 1980). Three states can be recognized in the normal grief reaction, and absence or prolongation of either of the early phases can be seen to be pathological.

The first phase, euphoria, is characterized by a positive attitude in the affected person and members of the family. This is probably associated with disbelief or denial of the impact that the disability will have on their lives.

In the second phase, recoil, the affected people undergo a series of emotional changes, characterized by depression, guilt or resentment ('why did this have to happen to me ...?'). Also they may be pre-occupied with the nearness of death, in this phase, particularly after a sudden onset of disability, such as in the case of stroke.

In recovery, the final phase, they start looking forward to the future and start to plan, realistically, what can be done. They begin to accept their loss, instead of rebelling against it, and to rebuild their lives in the changed circumstances.

Each professional needs to be sensitive to the person's attitude to his or her disability, and be aware of which stage is being passed through. For example, it is crucial not to deny the earlier stages, by pushing a premature optimism towards rehabilitation. Each person needs time to work it through and to adjust. The team has a responsibility in preventing the development of a pathological grief reaction to disability, by providing every assistance to the person and family in the necessary working through process. When the recovery phase has been reached, the occupational therapists can encourage the person to discover and solve practical problems that will occur. The person's home could be visited and ways of making it more accessible by the installation of a ramp and hand rails could be discussed. In this way the disabled person, and family, are utilizing coping mechanisms that will help them face the innumerable problems that disability can create.

Social changes

In addition to functional and psychological changes, there are changes in the way disabled people perceive themselves, their roles in society, and in the way they are perceived by others (Myers 1965). A 25-year study on long-term stroke disability in the United States (Gresham et al 1979) found that the most limiting disabilities—institutionalization and dependence in mobility and self-care—are fortunately the least prevalent. The more frequently found types of disabilities are those in which psychosocial and environmental factors play a large part; these include decreased social life, decreased vocational function and limited access to public transport.

Stroke is a degrading experience, especially in the early stages when a person may be incontinent and unable to carry out self-care activities such as toileting, dressing and eating, independently. Problems of self-esteem are magnified if there are communication or comprehension difficulties such as aphasia or dysarthria. Instead of being a useful member of society the person may feel a burden on family, friends, and the staff in the rehabilitation unit.

A major source of frustration for disabled people is that they cannot function in their usual social roles, of parent, wife, husband, lover, breadwinner and so on, because of their physical or mental handicaps.

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The rehabilitation team is responsible for boosting a person's self-esteem and in helping to re-establish them in their usual social roles as fully as possible. In rehabilitation, a person's involvement with family and community should be maximized from the onset of disability. For example, spouses should be encouraged to be active in physiotherapy sessions so that they can understand and contribute to functional recovery. After all, they are the ones who will be continuing the rehabilitation process by helping the person to dress, walk and get around in day-to-day life. This involvement also maximizes ease of transition from live-in rehabilitation units back into the community. The ability to go home is mainly dependent on social and environmental circumstances and not on level of independence or function. While some persons with severe disabilities are cared for by their families, there are others, with only mild functional handicaps, who live in institutions because of lack of support from family, friends and the community in general. From the onset of disability the team needs to be aware both of the person's functional potential and how the person will be able to re-establish himself or herself in society. The team's goals can be shaped accordingly and the appropriate physical, as well as social and environmental preparations made.

While a major aim in rehabilitation is in moving persons with disabilities towards maximal levels of independence, it needs to be emphasized that loss of independence should not interfere with a person's individuality, productive status and contribution to society. Disabled people should be allowed to live in a way as closely resembling their previous lifestyles as possible. Participation, and individual expression, in social life, sport or hobbies should be encouraged, and disabled persons have the right to work and to contribute to society according to their capacities. Many disabled people are isolated physically and socially from society because of restricted mobility and because society does not expect them to be working or pulling their weight. As Genni Batterham illustrated in her film ‘Pins and Needles’, disabled people hate and fear being lumped together and hidden away in institutions. They want to participate in, and contribute to, society.

Summary
The functional, psychological and social changes that are caused by disability, and by stroke in particular, have been discussed to illustrate the complexity of the disabling process. These changes, which occur with disability, are all inter-related and dependent on each other. Therefore, it is essential that each member of a rehabilitation team has an understanding of the holistic nature of disability and of rehabilitation. People with disabilities have the right to be able to function in society to the fullest physical, mental, social and vocational usefulness of which they are capable. With an holistic approach towards disabled people and towards their rehabilitation we can help them to achieve these goals.

References
Carr J H and Shepherd R (1976), A Positive Approach; a handbook for the early care of the stroke patient, Cumberland College of Health Sciences, Sydney.

Further reading