EDITOR'S NOTE

Through this column, we hope that practitioners in general medical settings will gain more complete knowledge of the many patients who are likely to benefit from brief psychotherapeutic interventions. A close working relationship between primary care and psychiatry can serve to enhance patient outcome.

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Rehabilitation

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At the annual Academy Awards gala in California, there is always recognition for the Best Actor and Best Actress in a Supporting Role. When providing health care to the elderly, the major role is often assumed by the medical physician leading the treatment team. Other providers typically work to support his or her leading effort.

Periodically, the major role is assigned to one of the usually supportive members of the team. In the case of Mr A, there was an opportunity for the physical therapist (R.B.) to take the leading role. It was she who suggested that the psychiatrist (D.S.) help the patient "to adapt," while she worked with him to rehabilitate the necessary working parts.

CASE PRESENTATION (DR SCHUYLER)

Mr A, a 60-year-old Vietnam veteran, was admitted to our nursing home unit 2 months before he and I met. Three months earlier, he had been in his usual state of health when he had the onset of abdominal pain following a celebratory dinner at a restaurant. Diagnosed with appendicitis and a bowel perforation, he was admitted to the hospital and nearly died in surgery. His recovery required several months spent in intensive care. By the time he had recovered from the physical insult to his system, he had been bedridden for 5 consecutive months. He felt as if one life had ended, and a second life needed to begin. He had severe atrophy in both of his legs and a loss of arm strength as well.

His motivation to recover the use of his limbs was tied to his grandson, 1 of 2 boys in the family of his daughter and son-in-law. He was closely involved with this child from the outset, but when his daughter and son-in-law divorced, it fell to him to care for the children directly for several years. This period of childrearing was ended when he suffered a heart attack and was hospitalized. At that point, his daughter's marriage had reconciled, and the boys returned to their parents' home.

Now, the elder of the boys would start his senior year in high school in 9 months. His father planned to move the family to Tennessee 3 months earlier so that he could start a new job there. The grandson, however, wanted to stay in Charleston, South Carolina, while he completed high school. His plan was to move in once again and live with grandpa!

And so, Mr A's motivation to recover was directly linked with being able to return home (and be mobile) so that he could provide a place for his grandson to remain in Charleston.

PSYCHOTHERAPY (DR SCHUYLER)

Although Mr A had suffered a major depressive episode after his heart attack, no depression was in evidence now. "My legs are like spaghetti," he said, "but I guarantee you that I won't become discouraged."

Together, we examined his expectations for physical therapy. We discussed the events that occurred when he left the hospital in a wheelchair to be with his extended family. We focused on his progress and noted his plans for the future. On the occasions when he overreached, my task was to gently pull him

back and help him to formulate reasonable goals. When he acknowledged some anxiety related to his self-imposed deadline, I added the prescription of an occasional low dose of lorazepam to his medications. We worked continually to support his motivation and maintain his focus on the physical therapy necessary to reach his goal of going home.

Although he spoke briefly about his mother and father, his time in the service, and a brief marriage, we kept the focus on his rehabilitation and the achievement of the goal he had set. There were 10 sessions of cognitively oriented psychotherapy. It was expected that these meetings would continue to support the physical therapy work that was the focus of his treatment.

PHYSICAL THERAPY (MS BLOUNT)

I began working with Mr A upon his admission to our nursing home unit. He had already been at the medical center in acute care for 3 months after suffering a perforated bowel that was treated surgically and from which he had nearly died. His recovery was very complicated, involving a colostomy and several months of wound healing, tube feedings, aspiration pneumonia, arterial thrombi with surgical intervention, and prolonged bed rest. All of this resulted in considerable weakness, muscle atrophy, poor endurance, and a significantly declined functional status.

While in his acute hospital stay, Mr A was being treated by both physical and occupational therapists for strength, endurance, and functional skills training; however, he had made little to no progress. Due to his multiple needs, he was admitted to our unit with the hope of continuing therapy and improvement to a level at which he could either transfer to a rehabilitation facility or be discharged home.

My initial evaluation of Mr A found him to be dependent for mobility as well as for activities of daily living. He had very low endurance and was in significant pain due to a large abdominal wound that was being treated with a wound vacuum-assisted closure (VAC) and routine dressing changes by a wound care specialist. He also demonstrated little to no motivation to recover function. It appeared as if he had lost the will to try.

When asked what his main goal for therapy was, Mr A answered, as many people do, "I want to walk again." Very few of my clients have the insight to know at the start what the challenges are that lie ahead of them, nor do they realize that they will have to reach several smaller milestones along the way before we can consider if and when they will be able to walk on their legs again. It is my job to understand this and to gently help my clients build an awareness for these necessary steps while we work together to find what motivates them.

For the first month, Mr A worked through a great deal of abdominal pain, nausea, and shortness of breath. I worked with him on bed mobility and sitting balance as well as range of motion of his extremities. I encouraged him to initiate using his extremities again. Pain in his abdomen and right shoulder limited his mobility and tolerance; however, it was also obvious that we had not found a motivating factor as of yet. He made very little effort to use his uninjured arms or his legs. I encouraged him to spend time out of bed in a Broda chair (Broda Seating, Detroit, Michigan) or wheelchair, but he declined each time. With continued occupational and physical therapy, he became able to transfer supine to and from sitting on the edge of the bed, with the maximum assistance of 2 therapists. He could tolerate a maximum of 8 to 10 minutes of sitting up, with help to maintain balance.

However, his balance was poor, and he demonstrated little to no self-righting reactions. His tolerance was low, and he often stopped therapy because of pain. He required a lot of encouragement to perform tasks such as bringing a cup to his mouth, feeding himself, or washing his face. Toward the end of the first month, Mr A learned that his son-in-law had gotten a new job and planned to move his family, including 2 grandsons, to Tennessee. When one grandson told him that he wanted to stay in Charleston with him so that he could finish out his final year of high school, this became a huge motivating factor for Mr A.

During our second month of therapy, Mr A made some gains in trunk control, tolerance of seated balance, and endurance. His pain began to decrease as his wound began to heal. His wound VAC and tube feeding were discontinued, and he experienced more freedom of movement. He began to be more willing to get out of bed and into a wheelchair. His time out of bed increased from 15 minutes to an hour. He began to initiate activity with his arms. He could now shave himself and brush his teeth and hair while seated in the wheelchair at his sink and mirror.

It was now time to attempt some weight bearing in his legs in order to move forward toward weight-bearing transfers. Mr A was surprised to learn that he was unable to stand, even with the maximum assistance of 2 therapists. Seeing how much work this entailed surprised his family as well. This was not, however, a surprise to me, as the patient had been bed-bound for 5 months.

During the next month, Mr A continued to improve his endurance and trunk control. We worked on increasing his tolerance to weight bearing in his legs using mechanical weight-bearing transfer aids. We continued to work on bed mobility, trunk control, balance, endurance, and arm and leg strength. During his fourth month of therapy, Mr A could tolerate being out of bed daily for up to 3 hours. He was able to maintain static and dynamic–seated balance on the edge of the bed and could stand with assistance.

He could transfer from the bed to the wheelchair with the assistance of 2 persons using a low pivot without a lifting device. He could now stand for a maximum of 15 to 20 seconds and move from the edge of the bed to a walker with assistance. He could scoot forward and back and move a few inches from side to side while seated on the bed and then stand with minimal assistance.

With each gain, Mr A was approaching the time for transfer to a more intense rehabilitation facility, or perhaps getting closer to discharge home. He was eager now and excited about his accomplishments. "I am determined to be able to go home and not be wheelchair dependent," he said. He seemed now to realize fully the importance of the many milestones he had achieved to reach his goal.