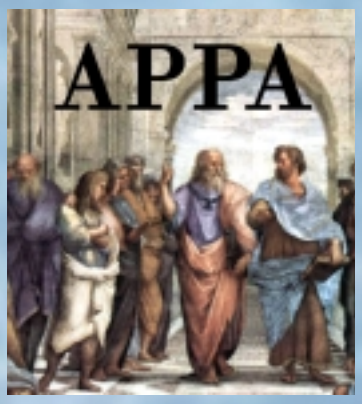

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Philosophical Practice in Rehabilitation Medicine
Grasping the Potential for Personal Maturation in Existential Ruptures

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Abstract

Rehabilitation medicine, aka Physical medicine and Rehabilitation (PM & R), is the medical specialty which focuses on optimizing function, ability, participation and life satisfaction in the light of noncurable disability and/or chronic disease. It is primarily geared towards the "so what" (i.e. consequences) than towards "what" (i.e. causes). PM & R is holistic and patient-centred, thus comprising a well-suited arena for dialogue and patient participation. Many patients experience a severe crisis reaction in the aftermath of major trauma or disease. This "existential rupture" calls for a fundamental revaluation of many aspects of daily life. Crisis management will not merely be a matter of mourning and then back to "business as usual," as this often is either not possible or not the optimal choice given altered life circumstances. We propose that philosophical practice (PP) may be an important addition to the rehabilitation process, by facilitating "lifeworld analyses" and thereby making it possible for the patient to find sources of meaning in life despite disability. This "therapy for the sane" (albeit disabled) comprises PP rather than psychiatric or psychotherapeutic interventions, and may come to be seen as a key aspect in the training of future physiatrists and other rehabilitation specialists.

Keywords: *rehabilitation medicine, philosophical practice, crisis management, spinal cord injury*

Rehabilitation Medicine: Scope and Characteristics

Rehabilitation medicine, aka Physical Medicine and Rehabilitation (PM & R), is one of the younger specialties that have branched off from internal medicine. As medical knowledge grows exponentially, it has long since become impossible for one individual to master all of the healing profession. PM & R shares with Family Medicine the paradoxical characteristic of being specialized in being holistic. Above all, PM & R focuses on functional *consequences* of disease or injury, aiming at minimizing any residual functional impairments, while maximizing abilities, participatory capacities, quality of life and life satisfaction. As most organ specialists are focused on diagnosing etiology, effectuating causal treatment and—whenever possible—achieving "cure," PM & R takes over the therapeutic task of making the best of the situation in those (all-too frequent) situations were such cure is impossible. Roughly then, acute medicine focuses on the "*what*" of disease, while PM & R focuses on the "*so what.*" In contradistinction to what is the case in most other specialties, the role of the rehabilitation physician (known as a *physiatrist* in the US) is that of a coordinator, rather than a solo player. In relation to the patient, the role of the physiatrist physician is, more than what is usual among physicians, that of an adviser. All in all, the role of the patient is much more central. In surgery, the role of the patient is typically to be put to sleep prior to being treated, thus not even being conscious during procedures. This way of working is totally impossible in rehabilitation medicine. Treatment cannot be "performed" on a passive patient. To the contrary, the patient has to be an active *participant*, both as regards goal-setting and prioritizing as well as in effectuating the rehabilitation process. Nobody else can "do" the rehab for the patient.

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Still, PM & R is all-too-often working according to an outdated reductionistic, biomedical paradigm. Many rehabilitationists continue to work as if a Cartesian mind-body dualism were valid. This state of affairs is unfortunate, and has to change in order for PM & R to live up to its credo of being experts in working with the whole person in her context. Here we hope to find a key role for philosophical practice (PP). Let me start by illustrating the crux of the current situation by way of a short case study.

Case # 1: When Sven Broke His Back

Sven (not his real name) is a 25-year old single male, living in a rural area in northern Sweden. He dropped out of school early, and works as a lumberjack. His hobbies are thoroughly physical, including mountain biking, speedway driving, snow scooter racing and soccer playing. He has always been physically and mentally fit and healthy. One day at work, a load of timber accidentally is released on him, leading to a spinal column fracture of the fifth thoracic vertebra and a complete spinal cord injury (SCI) below this level. This leaves him completely paralyzed from his chest down, for the rest of his life. During the early post acute phase, Sven is very upset and sad when he realizes what catastrophic injury he has sustained. An acute psychiatric consultation by the liason psychiatrist is undertaken. According to the psychiatrist, Sven suffers from a physiological (i.e. "normal") crisis reaction, with no signs of major psychiatric disease, and he is prescribed anxiolytic and antidepressant medication.

The following in-patient rehabilitation process is uneventful, and Sven is discharged to his home 2 months post injury. He is referred to a general practitioner (GP) for follow-up "as needed." After returning home, Sven experiences the full consequences of his paraplegia in terms of making his former lifestyle impossible. He becomes more deeply despaired, and even contemplates suicide. He cannot return to his old job, which he loved, and he cannot participate in his hobby activities anymore. When consulting a GP for some medical problems, he mentions in passing his feelings of hopelessness, boredom and despair. No dialogue is offered, but the dose of antidepressant medication is increased. Two years post injury, Sven is still on antidepressant drugs. He has decided not to kill himself—at least for now, but he feels his life is void of all meaning. He is not working, he drinks too much alcohol, spends most of his nights hooked to his computer, and has very limited social contacts.

Comment on Case # 1

This, tragically, is an all-too-common outcome after severe trauma or disease, such as SCI. The inevitable functional impairments preclude Sven from returning to his previous lifestyle and habits. Since he is (correctly) not considered mentally ill, very little can and will be offered from psychiatry. The antidepressant medication is only of very limited use, again because no psychiatric *disease* is present, and because the medication does not remove Sven's existential vacuum.

Is this sad state of affairs inevitable? I believe not. Before focusing on this question further by way of another case study, let me underscore the tragedy of Sven´s predicament. The tragedy no doubt includes the irreversible functional impairments caused by the SCI. The task of preventing and finding cures for such neurological damage remains a key challenge for modern medicine including PM & R. This is something that will bear fruit in the future. It will not help Sven here and now. It should be recalled, that it is only since the middle of the 20th century that SCI patients survived at all. Over 80% of patients died within two weeks of injury. Due largely to the implemen-

tation of modern principles of rehabilitation patients now as a rule survive many decades after injury, with prospects of excellent physical health, despite permanent disability. However, this dramatic improvement in survival prognosis leads merely to survival but not to "a life" in Sven's case. He survives, yes, but to a life subjectively emptied of its meaning. Is this because life as a paraplegic *a priori* precludes living a meaningful life? Not at all. To the contrary, there are legions of living examples who falsify any such notions by their actual life stories. From a "here-and-now" perspective, the greatest tragedy exemplified by case # 1, however, is *not* Sven's irreversible bodily injury as such, but rather the failure on behalf of us health care providers to help Sven find *meaning* in his new life. This requires qualified coaching through dialogue, not pharmaceuticals. Neither will purely physical interventions as such create meaning, although just like pharmaceuticals they may contribute to increase "functionality," and thus indirectly facilitate the finding of meaning by making more options available. Sven is yet another casualty to the lack of attention and services aiming to deal with that which is not going to be "fixed" by neurological or psychiatric care components. The vacuum in Sven´s lifeworld *is* a pressing concern for PM & R, as it is exactly this which precludes Sven from being able to enjoy the life that was saved. The operation was successful, but the patient died, it is sometimes said. Here, rehabilitation of Sven's body was successful, but the patient died spiritually.

What, then, would the adequate intervention be in situations like this one? I believe one answer to be "therapy for the sane," i.e. philosophical practice. Why? Well, Sven is—as corroborated by the psychiatrist—"sane." Unhappy? Yes. Distressed? Yes. Sad? Definitely. Insane? Emphatically *no*. Sven has experienced a shattering of his former lifeworld—an "*existential rupture.*" His previous sources of meaning in his life are no longer available to him—or so it seems. Situations such as these make philosophers of everybody—for a while. The "therapy" that is missing here is the attending to Sven's urgent need to explore alternative avenues to find meaning in his life after injury. The benefits of such an approach can be suggested by the next case study.

Case # 2: When Inga Broke Her Back

Inga (not her real name) is 31-year-old married preschool teacher, living in a semi-urbanized area in central Sweden. After completion of high school, she took a job as a receptionist in a medium-sized firm in her hometown. She is interested in sports and literature. She married two years previously and is contemplating having children. During a holiday abroad, she dives into the shallow end of a swimming-pool, and sustains a spinal column C6-7 vertebral fracture dislocation, causing a cervical-level SCI, leaving her totally paralyzed in her legs and partially paralyzed also in her arms. Additionally, she loses all sensation from the upper part of her chest and down. During acute inpatient rehabilitation post injury, Inga is very sad and cries a lot. The liaison psychiatrist finds no signs of psychopathology and diagnoses her with a "crisis reaction." She is prescribed anxiolytic and antidepressant drugs. The following rehabilitation process in uneventful, but Inga expresses worries about both her future private and working life. The social worker in her rehab team has received training in philosophical practice, including APPA affiliate certification. Inga agrees to a series of ten dialogue sessions during her inpatient stay. These sessions are incorporated in her rehabilitation plan, along with conventional measures e.g. physiotherapy, contracture prophylaxis, training of activities of daily living (ADLs) *et cetera*. This means that she has to trade some hours of physiotherapy, and this is deemed acceptable by all parties. The social worker is supervised every second week by a philosophical practitioner. The dialogue sessions are documented in the medical record, and key points are discussed with the rest of the rehabilitation team

at their regularly scheduled meetings. Re-prioritizations of rehabilitation goals are made continuously, as indicated by Inga's insights gained in her dialogue sessions. After discharge from hospital, Inga and the social worker schedule a further four sessions, first once a week for two weeks, then once a month for two months. Three months after discharge Inga is back at her former job, now working half-time (in order to allow time for physiotherapy and ADL). One year later, she gives birth to a son. She and her husband maintain a rich social life, and at a follow-up outpatient appointment two years post injury, she claims to live a fully satisfying life. As compared to her life before injury, she has found new sources of meaning to compensate for those lost as a consequence of her physical disability. She thus reads more literature than before, spends more time with family and friends. By now being a mother, she directs more attention to this new and fulfilling role in her life than to her disability. She has found that being a good spouse, mother and friend in no way is precluded by sitting in a wheelchair. By having been able to reflect on what is really important for her, she has gained a better fit between her "philosophy of life" and her choice of activities now than even before injury. At that time, she claims, she simply hadn´t been aware of her own outlook on life. She had felt fairly happy, yes, but on a superficial, unreflective level. She claims that the existential crisis brought about by her sustaining a SCI made her "stop and think" much earlier in life than what would otherwise likely have been the case. In this way she feels that she has benefitted from having gotten the impetus to examine her choices and preferences, and then to adjust her life accordingly.

Comments on Case # 2

Inga, in distinct contrast to Sven, illustrates the tremendous coping potential available to many people. But potentials need to be actualized in order to be of any use. Inga was offered such an opportunity through PP, whereas Sven was not. Whether or not Sven would have been open to such an opportunity is of course not to be taken for granted, but given the potential benefits it certainly seems obvious that he too should have been given the option. By integrating PP as a key part of Inga's multimodal rehabilitation program, she gained the opportunity to first systematically reflect and then act on her new life situation. It is felt that the added focus on existential questions helped her reach a favourable outcome.

"Life competency": Putting Philosophy to Work in Medical Rehabilitation

I have contemplated ways of improving the current rehabilitation paradigm for some years. Some aspects of this paradigm—e.g. a high degree of patient participation and empowerment, multimodal and interdisciplinary activities according to a clearly defined plan, with measurable milestones and endpoints, and focus on the practical consequences in daily living—are exemplary for medicine as a whole, and should serve as a blueprint for the reformation of health care in general. These key aspects should of course be preserved and further developed. But, in my view, some crucial components are missing, or are at least severely underdeveloped. One such component is PP.

Each individual´s "philosophy of life" will influence his/her way of living. Many diseases and injuries are related to detrimental lifestyle habits (e.g. over- and malnutrition, smoking, drug and alcohol abuse, immobilization, stress). Such habits will have an even stronger impact on life with a disability, as this as a rule creates an increased vulnerability to various negative medical conse-

quences and complications. In order to change habits in the direction of healthier ones, there needs to be motivation. Motivation to positive change may be facilitated by various types of coaching.

Unfortunately, the current rehabilitation paradigm lacks explicit focus on "philosophy of life," lifestyle habits, and motivational work. For this reason, a government-funded pilot project called "Life Competency" was commenced in 2008 by the Spinalis Foundation of Stockholm, Sweden, in collaboration with a private rehabilitation center, Rehab Station Stockholm, the Section for Neurorehabilitation at Karolinska Institutet and the Section for Rehabilitation Medicine at Umeå University. As project leader, my colleagues and I have implemented health promotion and lifestyle interventions in the clinical rehabilitation setting. Already during the late 1990s, before the current project, we started working on motivation by use of cognitive behavioral therapy (CBT), adapted to the challenges of relevance in a rehabilitation context. The approach thus was more pedagogical rather than psychotherapeutic in its execution, with emphasis on lectures, readings and group discussions. However, we felt that the focus on "defective" or dysfunctional thinking somewhat missed the mark in this particular application. As a rule, there is an abundance of very real problems to think about indeed. Thus, although helpful to some degree, we felt our application of CBT was less than optimal for dealing with our patients in crisis.

So we redirected our attention to crisis psychotherapy. Seen from the clinical and medical perspective, most patients in PM & R experience major existential crises, which are left largely unnoticed and undiscussed. Even though "crisis management" in conjunction with trauma and loss is well known both from practice and in the literature, only certain aspects of the crisis have typically been emphasized. For example, an almost exclusive focus has been put on getting the patient/client "through" the "stages" of crisis (i.e. shock, denial, anger, *et cetera*) and then "back on the track." This, however, is oftentimes neither possible nor sufficient in the rehab setting, where the person, as a rule, will have to cope with permanent and sometimes progressive disability for the rest of life. Additionally, the opportunity for maturation and "wisdom" oftentimes concealed within the crisis is typically not sufficiently explored. One example of this is the sometimes called "lucky break," denoting a "dropped-out" person who, after sustaining a SCI, makes a 180 degree turnaround in life and becomes a happy and successful individual, claiming to live a much more satisfying life after than before injury.

Although such sunshine stories admittedly are very far from the rule, there is a not unusual clinical impression of a "window of opportunity" for change after injury or debut of significant disease. Speculatively, this window of opportunity may reflect the shattering of the person's lifeworld (what I suggest calling an "existential rupture"), where absolutely nothing can be taken for granted anymore. This openness to the "revaluation of all values" is seldom explicit, however, and is commonly missed in the chaos of all other aspects of severe medical insult. By actively offering a forum for dialogue about such questions as a matter of course, we believe that the opportunity may be grasped to the benefit of the patient. Simplistically put, trauma and disease makes "everyone" a philosopher—for a while. The skill lies in synchronizing the offering of PP to this time frame in which the patient is latently eager for counseling. By taking advantage of this (temporary) openness to change, our experience indicate that this will facilitate subsequent lifestyle changes. By staying clear of retrospective childhood trauma analyses, avoiding "psychologizing" grief and instead focusing on the "here-and-now" as well as envisaging a future as fulfilling as possible, philosophi-

cally and existentially informed dialogues may indeed prove to be a powerful "therapy for the sane."

In summary, medical trauma or disease often leads to an "existential rupture." This puts the patient in a philosophical state of mind, in which there is an openness to change and an urge for exploration of philosophical and existential issues. By identifying loci of meaning despite disability, the patient may not only be guided "through" the crisis, but may additionally benefit from a "revaluation of values" ultimately creating motivation for lifestyle changes and restored or even improved life satisfaction despite permanent disability.

Notes on Method

After screening some variants of PP, and after having had fruitful discussions with a number of prominent practitioners, we decided on a formalized collaboration with APPA and its current president, professor Lou Marinoff. Apart from being one of the pioneers of the contemporary PP movement, Marinoff also could offer a structured pedagogical input to the project through APPA certification. For a pilot research project it is of course necessary and desirable to be able to describe its different components, not least in order to facilitate subsequent replication and scaling. The educational and pedagogical efforts of the project in fact included a highly ambitious program stretching over a year, being offered to various professionals within the Rehab Station multidisciplinary teams, e.g. physicians, social workers, physiotherapists, nurses, occupational therapists *et cetera*. The philosophical input to the rehab programs takes two forms: 1) *Individual dialogue sessions* as part of the rehab program, under supervision of a formally qualified philosophical practitioner; and 2) "*Philosophical cafés*" at the center, where concepts of relevance for rehabilitation (e.g. independence, freedom, happiness, fulfillment) are discussed.

The project is currently in its third and final year. One challenge now is to develop guidelines for the execution and documentation of the dialogues. We are aware of the controversies regarding method(s) (or no-method!) within PP, bur for this particular implementation at least we want to operationalize some procedures. In the context of quality assurance and demands on evidence-based medical practise, it is natural to strive for transparency and scalability.

Seen from the perspective of the methodology already in use within PM & R (at least in Sweden), initial dialogues focuses on a structured or semi-structured *mapping* of the patient's "lifeworld," including concrete matters of fact, social networks, view of self and also "core values" (spiritual dimension). This "*lifeworld analysis*" complements and enriches the conventional work-up and mapping done as a matter of course at the start of each rehabilitation program. Along the course of dialogues, the patient may find alternative avenues towards a meaningful life in the face of medical realities, and such "re-evaluations" are then reflected in modifications in the setting of rehabilitation goals and plans for action.

After discharge from primary rehabilitation, day-care and out-patient follow-up services ideally should comprise a "PP component," both for individuals and groups. Not only patients, but also spouses and significant others may be offered to take part in these services. Seen in the long-term perspective, many patients will need readmissions to inpatient care or daycare, e.g. due to disease progression and/or aging-related problems, and again PP services should be made available as a natural component among others in the multimodal rehabilitation offerings. The value of imple-

menting PP in this context should be scientifically evaluated, just like any other therapeutic modality.

Demarcations

It is not without difficulties that implementation of PP in a medical context will happen. The resistance will vary from operation to operation, and from country to country. We are well-aware that our project is not the first effort of this kind, and we will welcome feedback from those who have experience in this type of endeavor. Leaving irrational turf wars aside, there are, according to my opinion, a few real issues to consider. First, some patients will of course suffer from co-morbid major psychiatric disorders. Such persons should receive expert psychiatric consultations, not PP. Thus, some form of *screening for psychiatric disease* might be recommended. Second, PP should not be imposed on anyone against his/her will. Here it is important to realize that patients vary substantially as regards their acute emotional reactions to injury or disease. Third, there is the issue of *timing*. It is probably unwise to commence philosophical dialogues until at least some degree of emotional stability has been obtained. The same goes for the patient's medical condition: a certain degree of physiological stability as regards vital functions is a requisite for meaningful dialogue to be able to take place. Fourth, PP has to be presented in an understandable way to the patient in order for him/her to be able to make an informed decision as to participate or not.

Conclusion

PP seems to be a promising and indeed well-needed additional tool, method or activity in PM & R by filling a void between psychiatry and body-oriented rehabilitation techniques. Major trauma and disease typically leads to an "existential rupture," with both a need and willingness for revaluation of life goals and modes of living. This time-frame on behalf of the patient, opening up for an inclination to "philosophize," provides a window of opportunity for the patient and rehabilitation team alike for capturing the potential for personal growth, maturation and adjusted goal setting that too often is wasted in standard models of care.

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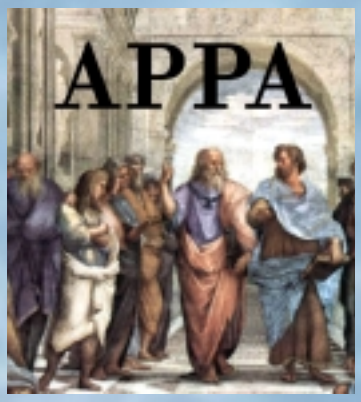

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Aims and Scope

Philosophical Practice is a scholarly, peer-reviewed journal dedicated to the growing field of applied philosophy. The journal covers substantive issues in the areas of client counseling, group facilitation, and organizational consulting. It provides a forum for discussing professional, ethical, legal, sociological, and political aspects of philosophical practice, as well as juxtapositions of philosophical practice with other professions. Articles may address theories or methodologies of philosophical practice; present or critique case-studies; assess developmental frameworks or research programs; and offer commentary on previous publications. The journal also has an active book review and correspondence section.

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