

# Culturally Adjusted Rehabilitation Models



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No other branch of medicine is as intrusive as rehabilitation. Treatment programs are personalised to the point of readjusting the very private habitat of an individual. Whilst as rehabilitation teams we state that our work is directed at reclaiming lost function, subconsciously we proceed to readjust functional status. The readjustment process of the personalised style of daily living can inadvertently become a process of remodeling, a step beyond rehabilitation. I have often observed the tragedy of the loss of a person "within" to the enthusiasm of rehabilitation teams and their process of action. Often rehabilitation processes deliver a modified individual, one that is alien to "Self". This sets off a long-term internal battle of acceptance of a very personal nature, as the individual struggles to readjust to his / her new identity. This, indeed, is a battle that is often lost by the one who initiates it. Whilst it is necessary to engineer "Self Alteration" for optimised rehabilitation outcomes in some cases, it should be the last choice of treatment strategy rather than the premier treatment plan.

Although rehabilitation medicine is a relatively young branch of medicine, the practice parameters must continually undergo critical appraisal and it is imperative that the fraternity practising it, should evaluate its current and ongoing practices.

I have now been working in the United Arab Emirates for just under two years. Through my experience of working with a large and varied expatriate community, as well as the indigenous population, I am beginning to learn that the current practice of rehabilitation, mainly developed against the background of modern western lifestyle, is unsuited to the needs of majority of world population. In this article I will argue that we need to develop Culturally Adjusted Rehabilitation Models (CARM) in order to achieve best outcomes for all our patients irrespective of social, cultural and religious backgrounds.

Each community of people has its own needs and life style, one that must be respected by those who seek to serve it. The life structures are constructed upon a framework of religious rituals, linguistic expressions, social demands and practices. These determine the pace and scale of activities, familial and social rights and responsibilities as well as vocational and occupational trends. For rehabilitation practice to be optimally successful in serving a community, rehabilitation teams must educate themselves about the prevalent social, religious and cultural constructs of the community they serve.

It is indeed unrealistically exhaustive to formulate a rehabilitation model for each community of people. However, there is an urgent need to develop a set of general principles that should

enable a rehabilitation team to tune its functioning to the need of the community that it serves.

I will introduce certain concepts that I have formulated during my period of practice in the UAE. I have learnt to give credence to several factors that I never considered objectively important during my years of practice in the United Kingdom. On reflection, it appears to me, that my training and lifestyle in the UK had given me sufficient insight into the life structures of the population I was serving and hence a conscious effort to take notice of such factors was not required. I was subconsciously programmed to design rehabilitation plans that were appropriate for the community I was serving.

Each community of people has a very specific response to disease. Whilst the varied response patterns are appreciated, these have not been accurately evaluated and are often the subject of broad-based statements of cultural sensitivity. The modeling of rehabilitation programmes whilst sensitive, may lack specificity. For example disengagement of family and patient empowerment may be considered rather an uncomfortable issue to approach in a hierarchical family setup but careful tuning of the rehabilitation plan to incorporate this as part of the program is seldom attempted. Having studied such issues I now believe that we must define certain variables that should allow us to tune and model programmes that would suit an individual patient's cultural and social requirements.

The first such variable I have termed "habitualised dependence". Whilst the term habitualised behaviour has been used in relation to societal institutionalisation<sup>1</sup> and on occasion there has been a loose association with dependency, this term has not been used to describe variance within a normal socially and culturally varied group of people. In this context I define "habitualised dependence as developmentally structured and promotional dependence upon artificially acquired facilities and modalities to enhance comfort and ease in daily living and social interactions".

This construct inherently demands a variability of behaviours of people depending upon their habitat, religious beliefs, practices and rituals and social setups. An individual living in the northern hemisphere is more dependent upon the need for a heated home, a hot water supply, well gripping shoes and several layers of clothing. As for a patient in the United Arab Emirates, the need is one for cooling systems, cold and plentiful drinking water supply and light clothing. However, added to the pressures of weather, religious influence maintains a degree of complexity in dressing. Furthermore, influences such as interdependence or interdependence and hierarchical family setup determine an individual's cognitive and

intellectual dependence or independence. Indeed the influence of cultural factors becomes paramount in the area of cognitive and behavioural habituated dependence. For instance a teenager may not have developed a complex decision making capacity in an excessively protective, supportive or dominant family setup. Dependence on maids, servants or helpers may also modify an individual's abilities in activities of daily and advanced daily living. Habituated dependence, or for that matter independence, may curtail or enhance the capacity of a person to interact with self, people and environment as an entirely self reliant individual. In modern times habituated dependence on equipment such as elevators, cars, calculators, computers and telephones must now be considered normal in developed and affluent communities yet is still not readily accessed by the majority of the world population.

In view of the above discussion it is necessary, for treating rehabilitation teams to have in-depth understanding of the prevalent normalised habituated dependence of the community or society that they serve. This should form the pivot around which the individualised rehabilitation plans are developed.

The second variable that I am beginning to take note of is "Impairment Realisation Time (IRT)". I define this as "The time up to the point at which a patient fully and consistently begins to realise that he or she has lost func-

Time (IDAT)". I have defined this as "time from IRT to full appreciation and acceptance of permanent functional loss of a body part due to impairment and clear indication of compensatory strategies being put in place to compensate". I have observed that different communities of people have different time spans over which this status is achieved. Quite interestingly I have noticed that shorter IRTs do not necessarily equate with shorter IDAT. Most available literature on disability acceptance is retrospective<sup>5</sup> whilst the IDAT has to be based upon prospective observations and evaluations.

The fourth variable that is vital to understand for good rehabilitation is the "Disability Adjustment Time (DAT)". I define this as "Time from acceptance status to a fully compensated and modified status that a disabled individual must achieve in order to establish maximally possible independent or care dependent lifestyle leading to the best achievable level of social and vocational integration or reintegration". Whilst disability acceptance is a widely understood concept,<sup>6</sup> work on culturally adjusted disability acceptance is rather lacking.

The second, third and fourth variables require scientific evaluation and quantifiable values attached to each. Inherently the studies will require multi-centre and multi-national collaboration. We are presently looking at setting up such comparative studies.

rehabilitation outcome extremely negatively. The treating rehabilitation team must know the prevalent belief systems in the communities they serve in order to pre-empt the risk. Strategies should be put in place early during the acute stages of management to prevent pathological hope taking roots. The task becomes complex as the team must not allow all hope to be extinguished and must avoid cultivating negativity and depression.

As will be seen from the descriptions of the aforementioned variables, rehabilitation models must vary for different communities of people in terms of reclamation and retrieval of lost functional status, time and timings of interventions, length of inpatient and community based rehabilitation and short and long-term supports. I do not believe that North American or Western European standards can be directly imported to and implemented in the United Arab Emirates or for that matter any other area of the world with the exactness with which these are adhered to in the original communities.

In this article I have presented some new ways of analysing the needs of patients requiring rehabilitation. There is a clear need to conduct work in order to quantitatively define the variables. This analysis should lead to defining the cultural and social constructs of the communities patients originate from, and allow the treating teams to develop Culturally Adjusted Rehabilitation Models (CARM). ♦

## For rehabilitation practice to be optimally successful in serving a community, rehabilitation teams must educate themselves about the prevalent social, religious and cultural constructs of the community they serve

tion of a body part and that there is a definite likelihood of this loss being partially or completely permanent". Whilst the phenomenon of "Denial" has been widely described,<sup>2,3</sup> I do not consider this to be same as IRT. Denial implies volitionally generated response whilst I consider IRT to be a conditioned response to injury. This conditioning is influenced by cultural, religious and societal factors. Furthermore denial has been considered as an interim coping strategy<sup>4</sup> and as such may be one of the expressed psychological phenomenon during IRT. I have further begun to realise that each community is likely to have a mean IRT with individual variations above and below the base line. As a crude observation I can state that patients from South Asia may have less IRT, as in my experience, unless complicated by perceptual deficits they begin to query the permanence of their impairments earlier than patients from other communities. This of course is only an observational statement and one that requires scientific evaluation.

The third variable that I would like to introduce is "Impairment to Disability Acceptance

Finally one other phenomenon that I now recognise is the negative impact of "Hope" on rehabilitation outcome. In the context of rehabilitation I refer to it as "Pathological Hope". I simply define it as "hope generated on the basis of belief that complete or near complete recovery of lost function will occur". The construct of pathological hope has been described in the literature.<sup>7</sup> Pathological hope takes firm roots in the patient's psyche and becomes so strong that it makes the patient virtually incapable of engaging in processes that invite him, or her, to accept and adjust to impairment or disability. Patients harbouring pathological hope believe that rehabilitative interventions are vehicles to achieving recovery and not modalities that lead to achieving maximum possible function given the level of disability. Patients who hold such hope fail to consider analytically the need for care support or equipment requirements and entertain all such provisions as temporary until near complete or full function is restored. Whilst over an extended period there is some dispensation and weakening of hope, lost time due to the pathological hope impacts on final reha-

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