BABES-BOLYAI UNIVERSITY

ECUMENICAL DOCTOR SCHOOL

CALVINIST THEOLOGICAL DEPARTMENT

Rehabilitation and Christian Counselling of Patients Suffering From Musculoskeletal Disease

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Introduction

I use interdisciplinar and holistic approaches in my research trying to find totality and know the person as a whole structure, that is why I have chosen the Ecumenical Doctor School of the Babes-Bolyai University.
I worked twelve years in the field of musculosceletal rehabilitation. As a deaconic -social worker, mental-hygenic expert my task was to help the seriously disabled people refinding their healthy „Self"-parts.
Under the torments of rehabilitation the Christian message of salvation and forgivness, love and the desire of acceptance attracts the patients several times. They often stand by Jesus in a critical situation. The questions of their counsling are rather complex.
If Christian people would like to help the disabled efficiently, they need a deeper understanding of the physical-psychic-social relations.
In my thesis, based on the Christian belief, I would like to demonstrate how people living with acquired disability cope with the catastrophe of their human existence, furthermore, how belief helps or blocks them in this process. It is also the aim of my research the role of Christianity, the cures of Jesus – the rehabilitation – in the field of contemporary medical treatments and the development of the image of counselling. My present work, deaconic and individual psychological knowledge and the experience, I have gained in the field of rehabilitation, forced me to write them up in my multidisciplinar scientific work.
I do this on the basis of Christian belief using its nature to integrate the comprehensive ideology and practical guidance of theology for Christian and non-Christian people, mentioning the different explanations and applications of psychological, pastoral-psychological, social and medical scientific methods.
After the injury rehabilitation becomes a lifelong process, which after about a year does not happen in strictly organized circumstances; when the patient adapts to his barriers, his social state changes, sets new aims and new interventions can be done. That is why it is necessary dealing with this problem.
According to Katona[1] the rehabilitational view is really desirable in each medical activity, but it rarely appears in practice. How it successes in different disciplines and the process of specialization are other questions. It is an urgent need that the related disciplines and those fields of science which deal with counselling – such as theology, clinical counselling, be familiar with this method. The rehabilitant needs strength to trust in the hope of relative changes, the main guidance is supporting the attitude of dum spiro spero (I hope until I live)!
This final goal can only succeed by the Jesusian rehabilitation!

The structure and the results of the thesis

After the concepts of the introduction I state my hypothesis and introduce my goals. Then I deal with the concepts of health and disease in the Old and New Testament and discuss the culture historical references, the medical

[1] Ferenc Katona, ed., *Orvosi rehabilitáció. Bevezetés*. In Ferenc Katona and István Siegler, eds. Orvosi rehabilitáció. (Budapest: Medicina könyvkiadó Rt, 1999), 18.

approaches, emphasizing the rehabilitation. I build their references into my thesis.
The following step is to take the concept, the division, the methods of intervention and rehabilitation into pieces, adding the catalys role of Christian counselling.
I write a new chapter to discuss the role and importance of counselling the more efficient rehabilitation.
In my scientific work I introduce the physical-psychic-mental-social changes of the patients suffering from acquired musculoskeletal disease from the aspects of counselling and the possible supports.
After all we get a picture of the attitude of **Jesus** in his healing process. He **never paid attention to the parts, but linked the conditions of recovery with belief**. When Jesus cures he christens and emphasizes the belief in a lot of other situations. For example: Philep then said: „**If you believe with all your heart, might**."
The role and significance of counselling has been proved during the research.
I reveal that the absorbation and acceptance of the disease is a suffering process and it can only be done by the adequate network of supporters (public health, social work, counselling) working together. This is nedded by the rehabilitant and the family as well. Deep, sufficient and long-lasting absorbation can be reached by adequate counselling. The concept of rehabilitation, the cooperation and people image of the rehabilitant are in interaction.
The people image of the helping professionals influences the physical-psychic-mental and social process of rehabilitation. (Will it be a whole holistic rehabilitation or physical only?)
It is proved that the human being, as all other creatures on earth, have goals and functions set by God.
Furthermore I examine the psychic changes using the methods of the Adlerian individul-psychology[2], which says that the human being is one, it cannot be divided, so it must be examined as a whole.
Dealing with the character of the individual it is obvious that it is formed by his place in the community, his adaptation, the desire of his success and his self-appreciation.[3]
Adler said[4] that theology serves the providing and maintaining of life, and I also emphasize its examination in my research. I ask questions which reveal the patient's statement before the injury, the period which had past since then, and his relationship with God.
I start with the individual's goals and take into consideration his activities, thoughts, image of God and people.
Those who take part in the rehabilitation are examined in holistic relations, and I map the social and mental circumstances parallel to the physical-psychic factors.
I use the self-centered non-direct therapy, and the Rogerian thought[5] published by Tringer, that in a therapic relationship the consultants acceptive warmth offers the client the possibility of expressing his feelings, attitudes and problems entirely without any boundaries or personal compulsions.
I reveal that beside the medical rehabilitation the social re-studying should start paralelly, which includes financial support, aid supply, the provision of adequate living and traffic

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[2]István marosi Máday, *Individuálpszichológia* (Pantheon, 1940) 15.
[3] The rethinking of the Adlerian point of view by Máday op. cit. 15.
[4] Edit Frencz Szélesné, „Az individuálpszichológia értékei az egészségpszichológia számára,"in *Az individuálpszichológia útjain. A Magyar Individuálpszichológiai Egyesület folyóirata.* 3.1 (2006)
[5] Gábor Hézser, Tájékozódás a case managementről Kézirat. Bethel-Bielefeld 2006. in Löcherbach Pu.a. Case Management (München, 2003) compare István Levente Fruttus and Gábor Hézser, Szeretet szolgálat Diakóniai Folyóirat III. !/2007-1/2008. 6-10.

conditions, the strengthening of social relations and the promotion of equal possibilities spending free time in a civilized way. Another thing is that I examine whether the social rehabilitation happens beside the physical one. In this situation one of my methods is the so called case-management.[6] I also demonstrate that the client becomes active by the optimal coordination of his claims, and the institutions' helping possibilities.

Beside the tracing of the problem solving strategies the mapping of the helping network and the research of their adequate connections can be seen. It also turnes out that in the resocialization of the individual the institutionalized background is indispensably important. In the following it is visible that after the medical rehabilitation the employment rehabilitation should be started directly, which needs such places of work, tools and conditions by which those who have difficulties or disabled can work without the deterioration of their state, and by which his role in society can be changed positively, but not negatively at all.[7]

Next to the facts introduced above it is inseparably important the research of the spiritual changes during the holistic approach. As I see beside the psychological help those who take part in musculosceletal rehabilitation examine their relationship with God during the process of mental care.

My study mentions whether the patients become able to help themselves by the clinical counselling (psychosocial help), furthermore, if this type of care helps them to pray again, rebel against the torments when they are in doubts.

I analyze if the person under counselling reaches the state when he can take delight in the gifts of God, his activities, the beauty of the nature. Has he got again psychical and spiritual I-knowledge, self-knowledge, self-value? Does he find his special image of God and knowledge of God? In this situation he undertakes the challenge of the disease.

In my research I discuss whether the patient becomes able to reintegrate into the community and participate in church services.[8]

In the following chapter I deal with the processing of my interviews from the point of individual psychology, case-management andcounselling.

I did my work in two places, in the rehabilitational hospital of the town of Nagykőrös and the MÁV Hospital of Szolnok. These hospitals receive patients from all regions of the country, there are not any area restrictions. In this case the research, although it could not become representative, shows wide cross-section of the population's rehabilitation. I took 100-100 interviews in each places, 200 ones altogether. I asked such patients whose disease had musculosceletal sympthoms. The interviewed casualties were all members of the adult population.

I did not tighten the definition of age with any other parameters, because the musculosceletal rehabilitation does not apply any other terms during the admissions. Only the really low points of the scales (under the point of 30, and serious speech and understanding disability) meant contraindications, and another restrictive factor was childhood. The musculosceletal rehabilitation of children happens in the National Medical Rehabilitational Center.

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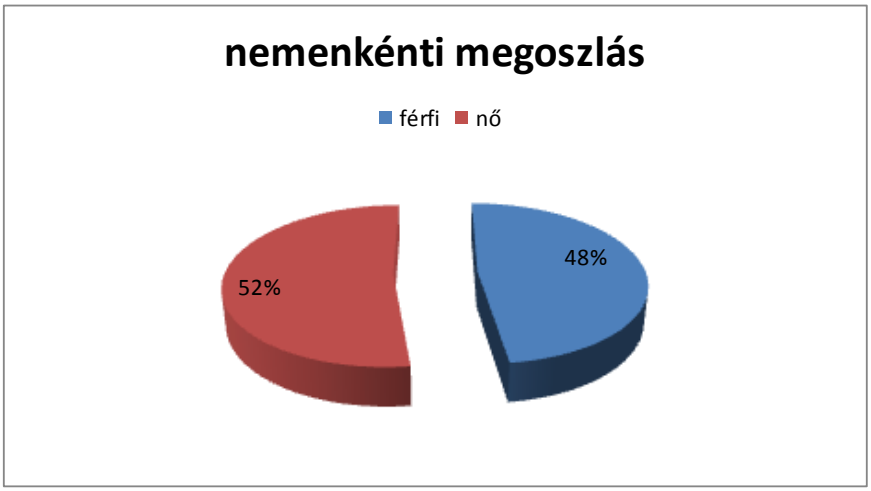
[6] László Tringer, A gyógyító beszélgetés. Semmelweis Egészségtudományi Egyetem Egészségügyi Főiskolai Kar (Budapest, 2003), 18.

[7] Hézser op. cit. 6-10.

[8] Katona & Siegler ed. op. cit. 18.

The division of the interviewed people according to their sex can be seen in the following chart:

Illustration 5.: Sex distribution (male, female)



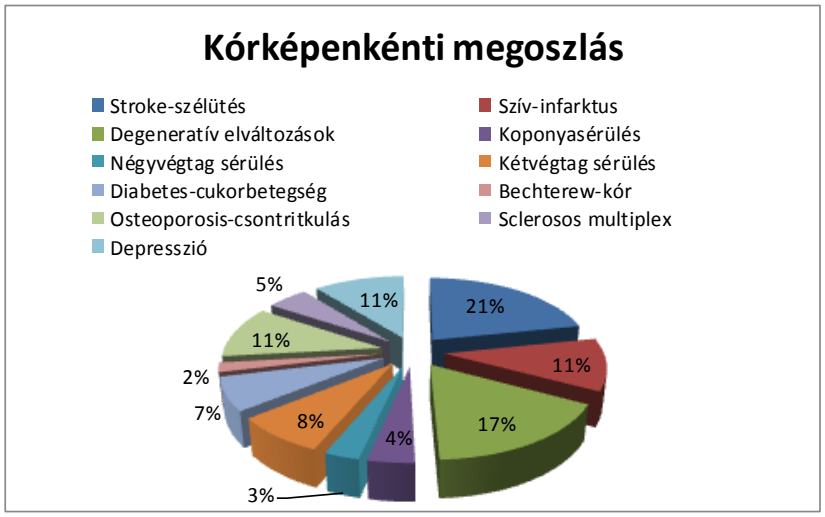
The chart refers to the fact that during the diagnosis of the disease significant difference cannot be seen as the rate of the sexes, but a 4% shift is visible to the females.
One of my methods during the research was the interview. The client can get rid of his anxiety by the discussion, so it is also a therapeutic tool. It is essential that during these discussions the patient can talk about his doubts, rebellions even against God, or he can vent his overwhelming feelings.

The results of the employment rehabilitational research which I use in my analysis significantly boosted the empirical part of my thesis, replaced my deficiency in objectivication in the field of psychic and mental immersion and corrected my emotional overwhelming.

Changing of physical state and musculoskeletal rehabilitation

The following chart demonstrates the distribution of the diseases in my research which need musculoskeletal rehabilitation.

Illustration 8.: Disease distribution



The result of the research does not correlate the international and national results

If the individual cannot do any useful activities it will be excluded, stigmatized, as Goffmann and Baumann also states[9] as well. The order of the society – in which the role of the health system is significant – is saved by written and unwritten rules, they have moral references. The ill, stigmatized person should learn these rules, and they have to face with the stigmatization, which is an impending factor of the civil existence.[10]

The relationship with God in the people under musculosceletal rehabilitation

There were some people who met God for the first time in this situation. A lot of them turned to God for help in their prays. There were some who had never prayed before. The following chart supports the previous statements:

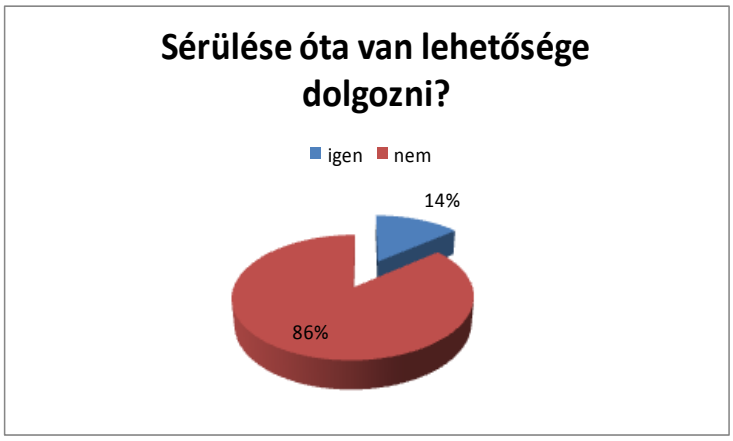
These results do not correlate with the results of the international and national results. Stroke is on the third place in the American data. In the developed European countries and in Hungary is the second most general vascular problem after heart disease, while in my examination it is on the first place,[11]which is the consequence of the special profile of the two hospital taken part in the examination.[12]
The pathographies of my interviewed individuals prove the sympthomes of the introduced illnesses, the processes of the intervention and the possibilities of mental care. The organic damage and disorganization of the physical structure were found in all of my examined subjects.
The cathalitic role of mental care in musculosceletal rehabilitation
In the following part I introduce that from the point of mental care it is essential that main point of the illness is the sight of need, the illness as an appeal declares itself.
Jesus blends in all cases! „” (Lk.20,22-31). With this humility and bending, he does not only bends, but also lifts us! „…and he sat and taught them…,…Jesus bended and started to write

[9] Molnár, Ószövetségi kortörténet. op. cit. 35-37.
[10] www.strokecenter.org/patients/about-stroke/stroke-statistics. Access: 23 May 2012.
[11] www.lam.hu/folyoiratok/lam/0801/5. Access: 23 May 2012
[12] B. H. Shulman and H. H. Mosak: *Manual for life Style Assessment.Introduction to individualpsychology*. (Chicago: Alfred Adler Institution, 1990), 18-22.

on the earth with his fingers…,….then he bended again and wrote on the earth…,… Jesus rose and stood and addressed him…”(Jn.8,1-11).
I attained tht the answers can be gruoped by similar tipology to Mosak/Shulman’s, which they wrote in 1990. Their division is the following: struggling, sacrifice-marthyr and passive baby.
Working up the interviews I found similar tipology: struggling, passive-waiting for the pigeon, sacrifice-suffering.
In the following it can be seen how the helped person can use the questions of case mangement to treat the difficulties, both in the field of mental stability and in his relation with God.
The wonders reveal that strugglers draft their aims, babies and marthyrs talk about their desires.
As a conclusion of wonders I can formulate that for the patients it is very important to have the freedom letting the past performance go, and discovering their new field of interest.
Their social interest leads to the following: participation, cooperation, dedication, mutual respect, the feeling of connection, being a member of a group, being aimed at an exercise.

Employmental rehabilitation and the habilitated patient

After making the interviews it became obvious that in several cases the rehabilitation finished in the hospital, and developing a new life strategy remained vain hope. After the survey of the psychosocial state and the hospital intervention it rarely happens that the patient is followed residentially, or he gets employmental rehabilitation. The market conditionsof preparation for new trades are not given today. Most of those clients who are at the age of being able to work lose their work after the rehabilitation.
Question: Has he got the opportunity to work after his injury?
The following chart supports the question:



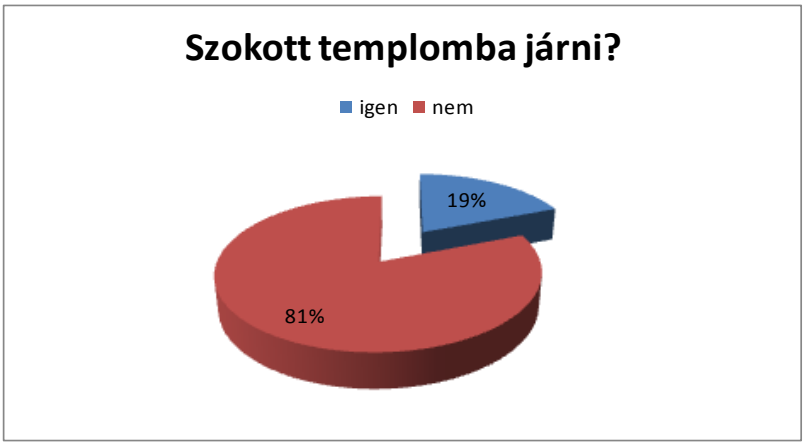
Can you work since your injury?

The patient drops out the manpower-market after his life's catastrophe, injury and illness, and and falls victim to existential free fall.
The employment centers do not hold up with new qualifications, or any jobs which need only teaching. The chances of reintegration into their original jobs are rather poor. The dyagram shows a frightening state, 14% works, this means 28 people from the interviewed 200.
It became unequivocal that there are more and more disfunctional parts in the system of the scheme which helps the permanently disabled people, the supports are on low level, and their controlling is also cumbersome.[13]
Although the creature of working facilities is not enough for the social integration, it is one of its most important factors. The hope of work gives the opportunity to the disabled to get income ensuring his living by socially recognized activity, and not loading the budget of the passive supply.[14]
If the individual cannot do any useful activities he becomes **excluded, stigmatized**, as it is also said by Goffmann and Baumann.[15] The order of the society – in which the health system has a crutial role – is saved by written and unwritten rules, they have moral references. They must be learned by the ill, stigmatized person. He has to face with stigmatization,[16] which is among the inhibitory factors of civil existence.

The relationship with God of the musculosceletally rehabilitated people

There were some people who met God in this state for the first time. A lot of them called God for help. There were some who had never prayed before. The following chart proves my statement.

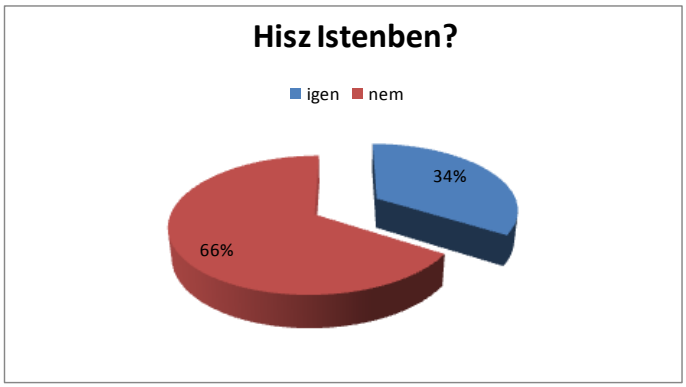
Do you go to church?



[13] Vitairat a megváltozott munkaképességűek foglalkoztatásának elősegítéséről. (2005) 1.
[14] Áepád Fekete," Alapvető szemléletváltás a fogyatékkal élő emberek foglalkoztatásában," in Fekete, et al., ed. A foglalkoztatási szint emelése a fogyatékos személyek szempontjából és annak jogi rendezéséről, összhangban az új 2003. évi CXXV. Törvénnyel. (2004) 4.
[15] Goffmann op. cit. 263-292.
[16] Ferenc Grezsa, Bevezetés a mentálhigiénébe (Segédanyag posztgraduális mentálhigiénés képzésbe) (T.F.: 1998) 9.

Those who met God first at the rebalilitational ward thought that God had not necessarily been living in the church, but they can have a church service where people congregate in his name.
A rehabilitational ward can be suitable for this purpose, too.
„That if two of you shall agree on earth as touching any thing that they shall ask, it shall be done for them of my Father which is in heaven. For where two or three are gathered together in my name, there am I in the midst of them." (Mt. 18,19-20)

Do you believe in God?



In that different state they were able to ask God for help until their brain did not obey to turn for human help. In this section of our discussions a new dimension opened, too: the healing and fulfilling good news of Jesus. It was a great opportunity for the the client to find the feeling of compassion and win consolation by Jesus under the pains and hopelessness. They stepped over the thought of sensing themselves as individuals, experienced the community with God and that they were not alone anymore.
Reaching these questions the importance of the councellor's attitude have been drawn up.
The demonstration of the previous difficulties raised my awareness to understand that the catastrophes of life, illnesses get the patients to draft the questions of belief.
The importance and depth of belief can only be unfolded in this situation. Where the strength of belief is concrete is the musculosceletal rehabilitational ward.
An explored item of the thesis is that in our therapeutic connections it is not only the client who must adopt to the changed situation, but we as counsellors as well.

Untapped resources

In the following it will be demonstrated what untapped resources can be found in the field of counseling. We don not use the human force of the congregations, although I have experienced that they had some more capacity.
In my thesis I emphasized the relationship, interaction, as well as the supporting network of the fellow disciplines. Rehabilitation, as I introduced, has formed into a lifelong process, and the helpers coordinated and continuous presence has become essential in the therapy of the rehabilitant.
In connection with the research it was proved that the supporting cooperation of the related professions help the patient in the more purposeful reintegration.

My next step is to confirm or reject my hypothesis.
The final conclusion of the research is that it is desirable to prepare orientation materials for deaconic-social worker student studies and church workers (vicars, deaconic workers) in the Hungarian-speaking regions. The material should contain theoretical and practical guide, which provides insight into the symptoms of musculoskeletal disorders and rehabilitation. I must help the counsellors, patients and non-professional helpers with information for the better understanding of the relations with disease.
I express the restoration of volunteer work' s value as one of the most important exercises in hospitals and at the Calvinist congregations. Organization of courses are urgent for achieving these goals.
Being aware of these facts the mottos of my research work are the two essential Jesusian sentences: „Do not be afraid, believe only!" We can read in the Romans: „…Who against hope believed in hope, that he might become the father of many nations, according to that was spoken." (Romans 4,18) Jesus also wants us to have belief, but we should ask for it, and accept it again and again.
I also did my research as an informative work for the members of the congregation to have more background knowledge about musculoskeletal rehabilitation.
As a result I expect the reduction of prejudice in the field of musculoskeletal rehabilitation.
In my final thoughts I highlight the catalithic role of counselling in the musculoskeletal rehabilitation and emphasize Jesus's whole physical-psychic-mental healing.

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