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Post-Polio Clinics Directors Network
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Disclaimer: The following are unofficial notes which have not been read by or approved by the speaker.

Points of Discussion:

- Difference in post-polio clinic and in the traditional mental health clinic is that the folks seen in the Post-Polio clinic rarely are self-referred for a mental health consultation.
- In the post-polio clinic the behavioral health services are part of the complement of the services.
- It is a choice of the clients if they want to see a psychologist - we do not insist.
- Often times, especially in the initial interview, the client is seen with their family members present. This information is very valuable.
- Many of the folks seen do not have a formal mental health evaluation. May not fit the criteria for a formal mood disorder which is in contrast to the other health problems such as chronic health conditions.
- First visit is a diagnostic interview.
- If they become more comfortable with behavioral health services or the doctor recommends a specific skill-building type of treatment, we use a diagnosis of a structural disorder.

Assessment

- An assessment is done at the first session, the diagnostic interview. There is a psychosocial history form designed for a population diagnosed with post-polio. We are interested in social and marital history, drug and alcohol history, family history, the age at the onset of the symptoms and family at that time.
- Usually start the interview saying this is one part of the spectrum of services we have here and most people seem to be OK with that.
- First aspect of Dr. Cook's work is to interpret screening device, Beck, and relay the answers and just look for mental status and other co-morbid factors that may impact their treatment now.

Linkage/Referral/Advocacy

- If mental health issues or a formal diagnosis has been made, Dr. Cook's job is to educate the client on items such as depression or anxiety and help them get adequate health care providers in their area. A copy of the database of health care providers is given to the client.

- Dr. Cook frames this as working with the strength of the client such as problem-solving, coaching, and learning different techniques. Tries to bring it to a very collaborative, proactive, skills acquisition matter.

- Even if there is no mental health issue, some people may be referred to OVR, the YMCA or similar venues for non-fatiguing exercise such as Yoga.

- Some clients have a specific request for social services or supplemental income. We do not suggest they apply for disability.

- There are a lot of positives working beyond a paycheck, plus there is a label to "disabled".

- As an "advocate", Dr. Cook does not share his own personal feelings.

- The post-polio population has pride associated with it and they are often very hesitant to ask about SSD. Dr. Cook will talk to them about it in a realistic manner.

Interventions

- General support or education. Support often times is just supportive listening, not providing advice or analysis, just listening to their stories. Creating a supportive forum without judgment can provide a sense of validation or hope for the clients. Education - if the client's history reflects these findings - Dr. Cook talks about the lower divorce rate, resilient health in many ways, and other items.

- The issue of de-stigmatization is the perception of the client having to come to a clinic. Often times this is perceived as a pathology issue for them. It is a transition in their life. We are asking them to explore the option of assistive devices; asking them to listen to their body.

- There are instances where the re-emergence of the initial symptoms could be viewed by the clinic as a sub-clinical PTS disorder. It may not be affecting their relationship with others but may impact their socialization such as work may be a major hassle.

- Interventions may be in the form of memories or flashbacks. Individual may be OK and then something triggers their memory to give a unpleasant feeling and arousal such as increased heart rate or nausea due to the feeling.

- Use of various treatment techniques such as skills acquisition, relaxation training . not pushing the feeling away but seeing it for what it is . having an awareness. It is not a pathology or illness but the time for denial is not so robust any more. Look at it again in a different way.

Exploration - try to get a sense of the early defenses they were using . they may have been helpful at one time. We ask them to be more sensitive to their body. Interested in how people managed at that time.

- Another general intervention used in the clinic is collaboration - never use the term "non-compliant". "Collaboration" is being an equal partner.

- There is a certain degree of shame or sadness associated with the fact that they have done all the PT, working and walking, and they look at it as that is why they have post-polio. Dr. Cook tries to acknowledge that and tells them they did the best they could with what they had and look where they are right now. It is very important to communicate this to the client.

Specific intervention - most frequently is sleep hygiene/sleep education/sleep initiation and maintenance strategy as well. We have a handout designed for the clinic talking about all the categories of sleep initiation, maintenance strategies and physical relaxation.

- Usually guide them through a body scan identifying each major muscle group.
- Under the category of worry management strategies, Dr. Cook talks about the nature of worry built into the system for a reason . the distinction between "worry" and having something the worry about.
- Never tell someone not to worry. Acknowledge it for what it is.
- Mindfulness Based Stress Reduction (MBSR) - mind/body technique. Program developed in 1979 at the University of Massachusetts Medical School. It is an eight-week program, two hours a week. There are homework assignments six days for 45 minutes a day designed for chronic pain individuals but is now used for depression and impulse control issues.
- *Newsweek* had a cover story on MBSR. Encourage everyone to look at the websites for the research on MBSR.
- Generally people with pain report about 30% reduction through the techniques.

Comments

Interpersonal relationships - problems communicating to their families. They find it difficult asking for help. There is often a lot to be done at the interpersonal level. They have an enormous feeling of abandon - "I cannot talk about it because they are going to leave me again." It needs to be dealt with at the family again.

Their current families likely have surprisingly little insight as to what the individual went through as a child.

During the retreat, we educated the folks on Yoga and relaxation and a large number were learning relaxation. Learning those techniques and listening to their bodies was very good for them.

Reminder: After the last meeting, a survey about the process followed regarding osteoporosis with post-polio clients was sent to all the directors. If you have not already returned your survey, please do.