PRINCIPLES OF THE REHABILITATION OF THOSE SUFFERING FROM NEUROSIS

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REHABILITATION is defined as "restoration to a satisfactory physical, mental, vocational or social status after injury or illness, including mental illness. The status need not be the same as that preceding the injury or illness" (English and English 1958). The object is to get the patient as fit as possible and to teach him to live and work to his maximum capacity; this may be sometimes in spite of, and with the acceptance of, some residual symptoms. Rehabilitation may be concurrent with, and play a part in, therapy (physical or psychological) yet it has a distinct goal. It can no longer be considered just the process of readjusting the patient to his optimum role in society after active treatment has been completed, but rather a part of a total programme which includes preventive, remedial and restorative measures. (Jones, N. and Rappaport, R., 1955) (Du Bois, F., 1959; Kissen, G. and Carmichael, D., 1960; Simon, B., 1959; Stevenson, G., 1960).

Adjustment according to abilities

It includes every method used in an attempt to relieve the patient's symptoms, to alter faulty attitudes, to help the patient to face the stresses of life realistically and to enable him to take his place in the community at a level of work and social adjustment compatible with his capabilities, whether these are less than, the same as or greater than the level of adjustment prior to his illness. Treatment and rehabilitation are co-ordinated so as to minimise the patient's separation from his usual role in society (Mann, W. A., and Terhune, W. B., 1962).

The type of medical treatment employed, its duration and the environment in which the patient lives during treatment are important factors in the total rehabilitation programme.

It is therefore essential initially to assess the patient's clinical condition to decide whether lengthy treatment is necessary and whether such treatment can be carried out as an out-patient, or that some form of in-patient treatment is preferable. Furthermore, at the conclusion of treatment, arrangements must be made for the patient's resettlement in work and recommendations made as to the type of employment for which the patient is considered suitable if he has no work to which to proceed.

Combined efforts

To be effective, such rehabilitation may require the combined efforts of a number of individuals with special qualifications to deal with the many problems involved.

Such a team includes those specially qualified to assess the degree of disability, to formulate the steps necessary to its partial or complete cure, to evaluate the final results and to provide the maximum possible opportunity for the individual who has benefited from these services, to regain his position as a worker in the community to which his efforts and self-respect entitle him.

The team should include the psychiatrist, nurse, psychologist, psychiatric social worker, disablement resettlement officer and be supported by employers, welfare organisations and local health authorities.

In its various forms, psychoneurosis may be regarded as a disturbance of

inter-personal relationships occurring in an individual, many aspects of whose personality and mental life remain relatively unaffected and who is able to continue an existence which is in many respects normal and effective while at the same time retaining responsibility for managing his affairs and enjoying the usual social privileges. These disorders represent attempts to adjust to life which are unsatisfactory because of faulty attitudes and faulty emotional development in those who suffer therefrom.

Neurotic patients are greatly concerned about themselves and their symptoms, feel isolated from their fellow men; have lost in varying degrees their capacity for social enjoyment and satisfaction in work and are a burden to themselves and to others. Their symptoms are their way of dealing with life's situations conceived by them as frightening. These situations are either related to the environment in which they live and work, or are derived from their own inner dissatisfactions and conflicts.

The more severe neurotics not only feel isolated from their fellow men but also, perhaps because of this and their great self-concern, involve other people questioning them ad infinitum as to better methods of living in a symptom-free way as they often erroneously feel that others live. They constantly invite, manipulate or aggressively demand, help from others, while demonstrating an unwillingness to usurp control.

There still exists a too prevalent and ill-informed opinion that those who suffer from psychoneurosis do so mainly because of long-standing personality difficulties implying some defect of character or vulnerability to stress which is evidence of weakness and immaturity and tends to foster a defeatist attitude in prognosis. It is, of course, true that neurosis is a reaction of the personality but what is important in rehabilitation is to determine whether the precipitating factors lie entirely within the individual sufferer, or may in part, and perhaps a large part, be precipitated by environmental situations.

Heredity confers on each personality the capacity to perceive his environment in his own way and so the hypersensitive person is liable to breakdown more easily, whether a housewife, business executive or unskilled worker. This should not surprise us, since each and all bring to their job their personality maladjustments, their mood disorders, ambitions, conscientiousness, deep-seated inferiority feelings, family, financial and related difficulties, all accentuated by the pressures of the day. Daily life is a continuum of work, home and leisure, none of which can be separated, and disturbances in one sphere affect the others. Thus everyone approaches his job and his relationships with others according to his personality, education, abilities and state of health. What happens to him depends on the pressures inherent in his environment. Rehabilitation, therefore, entails initially an understanding and careful assessment of individual personality and of those factors in the environment which may precipitate neurotic reactions.

The majority of those suffering from neurosis are keen to work and are good and happy workers, only giving up because of incapacitating symptoms. For many, the factors precipitating the illness have no relation to the working environment. Indeed, to the hypersensitive and emotionally vulnerable, work is often a boon since for a person of narrow interests, keen on his job, it reduces anxiety. It is also an outlet for

aggression in a man who unconsciously chooses the heavy hammering job in the foundry. In the individual with limited social qualities it may be the chief means of contact with his fellow men.

Neurosis is no respecter of persons, being found in men and women of all levels of intelligence and social status; in fact, neurosis, with migraine and high blood pressure, is much higher in the Registrar-General's Social Class I than in any other class (Denis Leigh, 1962). This is an important fact, since the more intelligent, responsible, hard-working and successful citizen is often unwilling to acknowledge that he is emotionally ill. He thus avoids seeking skilled help until he reaches extremes of suffering, takes to drink, gives up his job or gets sacked. His rehabilitation is thereby unnecessarily prolonged.

It is thus evident that rehabilitation must be applied in accordance with the degree of neurosis determined by personality and environmental factors. The neuroses are the commonest of all psychiatric illnesses and most are adequately dealt with by general practitioners, and only the more severe or persistent come to the attention of the psychiatrist. It is with the rehabilitation of these that this article is concerned.

Initial interview

When a patient is first referred, it is important to devote adequate time to the initial interview. A sympathetic, friendly and interested approach will put the patient at ease and facilitate a rough assessment of the severity of the illness, the factors relevant thereto, and help determine what treatment is required. The psychiatrist should ask himself, "Why is the patient behaving in this way? What is at the back of his symptoms? What is their significance? Are there any precipitating factors in his environment? How can he be helped? How can he help himself?" The more learned about the patient himself and his personality, the better can these questions be answered. The patient is encouraged to describe in his own way how his illness started and then encouraged to provide information about his life history. The information required includes the usual medical and family history of mental illness or maladjustment and the patient's adjustment through all phases of development. Information as to how the patient has dealt with real or conceived frustrations and unhappy relationships in the family, social, marital and sexual spheres is important. This provides knowledge as to the positive and negative forces in his personality which can be used by him to co-operate in treatment and influence his rehabilitation. Added information may be provided at the time if the patient is accompanied by relatives or friends.

Such an interview, with time and skill, may provide all that is necessary effectively to cure and rehabilitate the patient, as illustrated in the following case:

> A happily married, conscientious, intelligent senior sales representative, aged 50, complained of palpitations and precordial pain and in spite of the results of negative investigations still believed that he had serious heart disease. He had difficulty in getting off to sleep and his sleep was restless and appetite poor. He had lost his self-confidence, interest in everything was reduced, he was irritable and unable to work. These symptoms had been present for about two months and followed his being summoned to a special conference to discuss the impact of a sales reorganisation programme which had been started five months previously and in which he had a major responsibility. The week preceding the conference he became apprehensive and enquired whether he should prepare any notes but was informed that the course would be entirely informal. On arrival he realised that he was ten years older than the others attending, and all looked to him as the expert. He panicked, left the conference within a few hours and did not return and was unable to work thereafter.
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> His past history indicated that he

was an only child, brought up by a dominating aggressive punitive mother of whom he was afraid, and a kind but passive father who drank excessively. He had some difficulty in adjusting to school and had been rejected by the armed services because of his "nerves". He was anxiety-prone and reacted badly to bullying or shouting or being made fun of. However, his work record was excellent and he was highly thought of by his firm with whom he had been for 30 years.

His rehabilitation consisted in assessing his clinical state, assuring him after consultation with the Industrial Medical Officer acting for management that his breakdown would not prejudice his reputation and career in the firm and he would not be expected to attend such informal conferences in the future.

He was sent back to the job and required no other treatment, and had still remained well when seen two years later.

This case illustrates what can be done at the simple level of the first interview by manipulation of the environment and that even a patient with a basically vulnerable personality and unhappy background can be rapidly rehabilitated when he breaks down if care is taken to understand all the relevant factors involved.

Out-patient psychotherapy

In others the initial interview may indicate that the personality of the patient is not so resilient and adaptable, where the environmental stress appears minimal and his symptoms are not sufficiently handicapping to prevent him from working.

Regular out-patient treatment sessions which encourage the patient to talk about his difficulties in his own way will then enable the bits and pieces leading to his breakdown to be linked up and a clearer picture of his problems presented. This will enable the patient to gain rapport with his psychiatrist and to ventilate his intrinsic and extrinsic difficulties and with reassurance and encouragement to gain intellectual understanding and thereby learn to alter attitudes and face life more realistically. Many patients are rehabilitated in this way and enabled to lead a fuller and happier life, to work more efficiently and to form better relationships with their fellow men.

In-patient treatment

The decision to admit neurotic patients to hospital will remain a debatable question until further research establishes the relative merits of in-patient versus out-patient treatment. Recent years have seen the introduction of Day and Night Hospitals but their value in rehabilitation is uncertain in the absence of scientifically controlled studies against other forms of therapy. However, Bierer and Browne (1960), reporting on a pilot project with a night hospital, state that this type of facility can prevent breakdown in some patients by allowing them to remain at work, not jeopardising their chances of promotion through absenteeism and the stigma connected with mental illness. The fact remains, however, that more neurotic patients are being admitted to hospital as in-patients every year. Many are treated in special annexes or units of mental hospitals while others are sent to special neurosis centres such as the Cassel Hospital or Roffey Park. Others are successfully treated in psychiatric beds in general hospitals and this choice of admission may well increase in the years ahead.

All patients suffering from neurosis are admitted on the recommendation of psychiatrists and most have had varying periods of out-patient care or attended Day Hospitals prior to admission. Experience leads to the conclusion that it is often essential for such patients to be taken out of the environment where they break down in order, with medical help, to take a more objective view of their condition. Furthermore, in-patient treatment is essential when the emotional factors are inadequately dealt with; where negative investigations for organic disease follow one another and the symptom pattern becomes fixed, relationships in the

home and at work suffer and the patient reaches a state of irritation and despair. These facts seem to indicate that in-patient treatment is essential for some neuroses and may well influence future planning for hospital accommodation.

Therapeutic community

Sociological studies have shown the influences which groups exert on individuals and this knowledge has been applied in the treatment of all forms of mental illness. Experience in recent years has shown the great value of a therapeutic community atmosphere in ameliorating antisocial behaviour, whether this be in the form of acting-out or in a retreat into illness. A patient in a therapeutic hospital community is experiencing psychotherapy at all times of the day.

D. H. Clarke (1963) provides an excellent review of the literature and the wide appreciation of the therapeutic community in the treatment of mental illness. He summarises the characteristics of such a community as: "Regular meetings of the staff and patients, staff consultative meetings, the examination of community happenings to help understanding and recovery, and constant attention to communication, authority patterns and role relationships of staff and patients; there is usually a well-developed programme of work, social activities and small group meetings". In England therapeutic communities with modifications in detail have been actively developed in a number of mental hospitals, including Claybury (Martin, 1962), Napsbury, Fulbourne, the Henderson Hospital, Roffey Park and some general hospitals (Dunkley and Lewis, 1963).

Advantages and disadvantages

There are many advantages in admitting patients suffering from neurosis to a therapeutic community environment. It provides opportunity for taking stock objectively of life situations where breakdown occurred while separated from it. The institutional life and discipline may provide a situation for recapitulation of childhood or adolescent difficulties in adjustment to authority and discipline which can be used therapeutically. The group phenomena influence individuals and help the socially immature and inhibited. The interaction between individual patients may reflect characteristic behaviour patterns and attachments which provide useful material for therapeutic discussions. The therapeutic regime with the traditions and morale inherited from previous generations of patients provides shared expectancy and inculcation of common goals, leading to an attitude of "get well" in a short period, all of which reflect the traditions of a healthy and stable society.

Where such a therapeutic community is far away from home there are perhaps difficulties in obtaining a "feed-back" of actual life problems. The inconvenience and limitations of community living may become a sterile preoccupation, diverting the patient from constructive self-appraisal. The dangers of imitation of psychopathic or hysterical behaviour, e.g. suicidal gestures, drinking and hedonistic immersion in pleasant social life, and of using the hospital as a retreat from difficulties, are ever present; while undesirable clandestine relations may also develop and add to the patient's emotional difficulties. There is the added economic loss to those removed from work, but this is usually negligible, since most patients are already too disabled to work. In general, the advantages far outweigh the disadvantages.

Return to work

Happy is the man or woman who has faith in the importance of his job, the admiration of his fellows for work well done and the sympathetic consideration of his superiors and fellow workers. To be out of work or unable to work is demoralising and creates resentment and irritability which permeates all inter-personal relationships.

The provision of opportunities for satisfying work is an essential step

towards the establishment of tension-free and rewarding relationships and the final end to a successful rehabilitation programme. The problems of rehabilitating the patient back to work can conveniently be considered under two main headings: (a) those unemployed, and (b) those who have difficulties in adjusting to their work.

(a) *The Unemployed.* When the unemployment level in a community is high, the neurotic patient may be under a special handicap in competing for work. This may stem from his lack of training, lack of skills, his intelligence, his inability to accept responsibility, or he may be so physically deteriorated and weak from neurotic symptoms that he is unable to work. He may, through his illness, have lost contact with external organisations that offer possibilities of employment. The need for a team approach is obvious.

The psychiatrist makes a careful assessment of the patient's physical and mental state and with the aid of medical specialists institutes the appropriate therapy. He will frequently find it beneficial to interview parents, spouse or relatives and explain how they can provide support to the patient. He will also decide whether supportive follow-up therapy is required and make arrangements accordingly. The psychologist assesses the patient's intelligence and aptitudes and provides vocational guidance. The psychiatric social worker examines the environmental situation in which the patient lives or to which he will return, or arranges in appropriate situations for accommodation with the help of local authorities or independent suitable hostels. He can greatly assist the psychiatrist in ascertaining the amount of support that can be expected from relatives and friends on discharge, particularly in the early stages of the patient's return to a normal environment. The Disablement Resettlement Officer will assist in arranging training courses where this is considered necessary for satisfactory resettlement, or will help place the patient in suitable employment in accordance with his abilities.

It is clear that every member of the team has a special contribution to make in placing the patient satisfactorily back in employment and society, and the usual procedure widely adopted is for all members of the team to meet together at regular intervals and discuss each patient's problems so that their combined experiences can ensure the best solution for the individual patient.

(b) *The Maladjusted Worker.*

Psychiatrists from clinical experience are well aware that over-anxious, indulgent, interfering, over-controlling, over-strict and unloving or neglectful parents can cause emotional problems in the child, adolescent and adult; that frigidity, impotence and jealousy create disharmony in marriage; and that the effect of the home environment and relations therein can limit the patient's working capacity through difficulties in human relationships.

Rehabilitation in such circumstances is often helped by discussions by the psychiatrist with parents, spouse and relatives in the patient's presence or alone. This enables faulty attitudes to be altered and makes for a better understanding between all concerned and may in some cases necessitate changes in the environment, e.g. the adolescent seeking emancipation yet dependent on home might benefit from being in lodgings and coming home for week-ends. Therapy may lead the patient to recognise that a complete change from the dependent role which he has adopted and which has been such a handicap, is an essential step in rehabilitation. However, even when the home environment is reasonably satisfactory, difficulties are often experienced in the working environment which can lead to neurotic breakdown.

Some impressions can be gleaned from patients admitted to Roffey Park. In 1961 over 30% of all patients were admitted directly from industry to Roffey Park and many others admitted from other sources

were also employed in commerce and industry. Studies of these patients show that their emotional disturbances can often be clearly related to and precipitated by the working environment. These cases also indicate some of the particular problems of the maladjusted worker and the need for manipulation of the environment in rehabilitation. Their rehabilitation is governed by the same general principles applied to those unemployed, with certain individual differences.

Frustration from work

It is often only after a careful appraisal of all the facts that it becomes evident that some of these patients break down because of dissatisfaction and frustration in the working environment. Their satisfactory recovery depends on their understanding of this relationship between work and symptoms about which they are often unaware without medical help, and their rehabilitation and the prevention of similar situations arising in the future. Experience at Roffey Park leads to the conclusion that breakdown, when precipitated by working conditions, occurs mainly in those who have difficulty in finding the right job, or in those who have risen to supervisory status as foreman or above.

An analysis of over 1,200 patients admitted to Roffey Park in 1961 and 1962 shows that 20 per cent of all admissions were due to situations arising in the working environment from which the following facts emerge:

(a) Traumatic neurosis arising as a result of injuries at work accounts for 11 per cent.

(b) Inability to find the right job is prevalent in adolescents and in immigrants.

The method for dealing with these patients after completion of treatment is vocational guidance and, with the help of the Disablement Resettlement Officer, obtaining Government courses where appropriate and, with or without such courses, placing the patient in suitable employment.

(c) Breakdown frequently occurs on promotion, being passed over for promotion, or changing jobs. Skill men with few leadership qualities sometimes promoted to supervis positions late in life, being selected management because of their excelle work and long and loyal service to th firm. They break down for sever reasons: (i) They are quite unable to as the intermediary buffer between thos under them and management and dea ing with the problems arising therefro (ii) They miss the satisfaction of the creative skill; (iii) They feel isolated an cut off from their previous colleague Their rehabilitation lies in their retu to their former skilled occupation. large commercial firms with their ow medical services, whether private o public, this can usually be arrange through the whole- or part-time Indu trial Medical Officer; in others personal contact with the firm throug the welfare officer or personnel manage who are only too willing to help valued and loyal worker.

(d) Others are similarly promoted as result of pressure from wives who env the status of the foreman's wife ne door. Learning that applications a invited for such a vacancy they persua their reluctant husband to apply. does so and gets the appointment, on to break down several months late Here the problem of rehabilitation is n so much the patient but the wife; ca she see that if her husband is returne to his supervisory job she may have possibly disgruntled invalid on hands, whereas return to his skilled jo will save his health and provide a secur economic status?

(e) The intellectual level of a patient ma be inadequate to meet the demands o his job. This is illustrated by the cas of a manager of a factory admitted t hospital because of palpitations, pani attacks and phobias; he had become irritable at his work and was causing difficult inter-personal relationships i the factory. On admission the symptom quickly cleared up. However, on assess ing his intellectual ability it was found that he was of just average intelligence He had been an excellent assistant manager where he could lean on th manager, but clearly his intellectual leve was inadequate to deal with polic matters and taking the initiative i major decisions. His resettlement neces sitated his return to the job of assistan manager.

(f) Middle-aged skilled workers wh

have spent more of their lives at shift work with periods alternating between day and night, particularly if employed on piece-work, not infrequently break down. Their psychiatric disability is frequently related to the domestic situation, with a menopausal wife, children grown up and leaving home, and a general feeling of loneliness. Such patients are torn between the domestic situation and the realisation that giving up shift work and taking a regular job may mean less in wages and therefore a lower standard of living. The resolution of the problem is a free discussion with the patient and his wife about the implications involved, enabling both parties to weigh up all the facts and reach their own decision. Thereafter recommendations can be made to the firm through the appropriate channels.

(g) Another problem that occasionally presents itself is that of the highly intelligent, skilled technical postgraduate in industry, whose academic achievements and brilliance are recognised and appreciated by management, who is considered for an appointment in the wider fields of executive status. An example is that of an electronics engineer, who, after some years with his firm, was given other duties outside his technical sphere, involving difficult personal relations, and broke down after a few months.

Careful assessment of personality traits and social qualities should be considered before taking such personnel out of their particular specialities and placing them in unaccustomed spheres where adaptation is difficult. In their rehabilitation it is better, where possible, to return them to their special fields. Prevention entails careful selection before transferring them to other executive spheres to give them wider experience with better career prospects.

Other examples of problems related to breakdown caused by situations in the working environment could be given, but enough has been written to indicate the importance of considering the environment in carrying out any rehabilitation programme. The clear establishment of such a relationship and steps taken to manipulate the environment, or place the individual in satisfactory work according to his intelligence and capabilities, will inevitably prevent a severe emotional upset and be a major contribution to the maintenance of good health.

The final resettlement of the patient in satisfactory work may depend on the attitude of employers towards those who have had emotional illnesses (Margolin, 1961; Wolfe, 1961) and is an important factor which must be recognised early. However, when, with the patient's permission, the employer is given all the relevant facts, with precise details of any limitations imposed by the patient's disability, and an assurance that prompt medical help is available and/or re-admission to hospital can be obtained quickly if required, there is usually little difficulty in finding employment for the ex-patient who is a willing worker.

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