Rehabilitation

Recovery From Mental Illness

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IT IS NOT POSSIBLE to discuss with finality the essential nature of disability produced by mental illness because of the complexity of personality development, marked individual differences in adaptation to stress, and great variation in ethnic and cultural milieu in which mental illness develops. However, it is currently assumed by many psychiatrists that mental illness is based primarily on difficulties in interpersonal relations that result in frustration of instinctive needs and strivings whose satisfactions are essential for normal growth and happiness.

The blocking or thwarting of these drives leads to unpleasant states of tension whose specific expressions vary over a wide spectrum. Tension is manifested in some patients by anxiety or apprehension; in others, it is transformed into obsessions or compulsions. Some patients fix their attention upon actual or fancied somatic complaints and become "psychic invalids"; others have major disturbances in autonomic balance resulting in malfunctioning of visceral organs (psychosomatic illness). Still another group is characterized by withdrawal, preoccupation with primitive fantasies, and attempts at resolution of psychic tensions either by inappropriate aggressive action or specialized psychic experiences such as delusions and hallucinations.

From another point of view, mentally ill persons suffer from deep-seated feelings of unworthiness that frequently break out in antagonism to authority, rival figures, or potential objects of affection, and that seriously impair their ability for work, play, or love.

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The Five Areas

There are five principal areas in which rehabilitative efforts to assist a patient should be applied: the patient's own psyche, his vocational and educational capacities, his family, and the social and recreational aspects of the community to which he will return. This concept of rehabilitation of the mentally ill approaches that of total treatment.

Psychological rehabilitation comes first in the hierarchy of concern. We are interested here primarily in reduction or removal of clinical symptoms, resolution of disruptive anxieties and tensions, and neutralization of intrapsychic conflicts. This is primarily a psychodynamic-therapeutic problem and is best managed by intensive individual or group therapy together with all other measures available in the hospital and outpatient setting. It is worth stressing that for many patients there exists a "psychopathological ceiling" which limits adaptational growth very sharply. For these patients, the critical psychological problems first must be dealt with and resolved before further rehabilitation effort can pay off. For other patients, however, though psychological problems may be sharply limiting, marked rehabilitative gains can be made through employment of methods indicated below.

Vocational rehabilitation involves careful assessment or survey of a patient's occupational or vocational interests and capacities, testing

his fitness through occupational assignment, developing old or new skills via occupational or work therapy, and increasing his work tolerance. It proceeds to training outside the hospital setting where indicated, assistance in job placement, and followup of vocational adjustment through contacts with the patient and, where possible and helpful, with the employer. The vocational counselor provides a link with the outside world. Often the anticipation of work and its connotation of status in the community provide a major impetus in stimulating a patient's desire for recovery.

Educational rehabilitation can often be helpful. To begin with, the experience of being mentally ill and of recovering, plus all the self-understanding that recovery usually implies, may make a profound contribution to a person's psychological education. Additional efforts to develop more fully the person's skills, talents, curiosities, and special interests are often worth while. Thus, mental hospitals have included programs of art, music appreciation, language instruction, photography, carpentry and cabinetmaking, the dance, and lectures by teachers of local institutions as part of the rehabilitative procedure. Through the stimulation and support provided by a rich rehabilitative program, many patients have discovered that totally new areas of curiosity, competence, or striving can be developed.

The patient's family is the fourth area in which rehabilitation is important. It seems clear that psychiatry in the future will involve itself increasingly with the family and its problems. Child psychiatry points the way by extending treatment simultaneously to both child and parent. Recent studies indicate that the patient's breakdown is often part of a major struggle going on in the family, with the patient the victim of character disturbances of other family members, longstanding feuds, or basic incompatibilities. The beneficial effects to the patient of hospitalization and the total plan of treatment may be vitiated unless his family also is given considerable support and understanding. Furthermore, major changes within the family may occur as the result of a patient's hospitalization, and these may in turn affect him. Mental or physical stress in one or more family members, stigmatization of the family by friends or the community, moving to another community, or closing of family ranks against him—especially if his illness assumes a chronic course—are examples of changes likely to affect a patient adversely. Thus, the family must be brought within the therapeutic orbit if the patient's rehabilitation potential is to be realized fully.

Experience indicates that the community is one of the weakest areas of patient adaptation and one towards which relatively little treatment effort is directed. Yet it is generally felt that those patients who develop deep roots in the community are least likely to have relapses. The ex-patient may go through the motions of a job, indeed be quite productive, yet be unable to tolerate social contacts, dependent as he is upon ease and naturalness of association and confidence in himself. Part of the difficulty is the unavailability of suitable sociorecreational groups—halfway groups, so to speak—that have the tolerance appropriate to each stage in an ex-patient's reintegration.

Phases of Therapy

There are three phases of the patient's illness during which rehabilitative efforts must be applied: first, during his hospitalization; second, during his transition from hospital to community; and third, during his community life.

In the hospital, rehabilitative emphasis is on achieving a "therapeutic climate," that is, an interpersonal atmosphere calculated to undo the pathogenic relations of the patient's earlier life. Therefore, personnel in the aggregate should be accepting, sympathetic, uncritical, interested, and understanding. Within such a climate three general patterns of treatment may be stressed.

The first form of treatment is intensive, individual psychotherapeutic work with a trained, professional therapist. A steadfast, reliable relationship that explores thoroughly a patient's thinking and feeling can be a remarkable catalyst for growth.

The second aspect of treatment is "milieu" therapy, and here we imply not only the "therapeutic climate" mentioned above but also a program that makes available to the patient

many activities, diversions, and socializing possibilities. Active occupational therapy, recreation, work, and sports programs are essential. Most crucial, of course, are the relationships developed with other persons—staff or patients—in these activities. Often the milieu program can be successfully supplemented by additional group experience such as formal group therapy or patient government.

The third area of emphasis is somatic therapy. Here we include all efforts directed toward removal of physical or physiological handicaps and, in addition, specific somatic treatments, including electric shock, insulin, surgery, and pharmacotherapeutic agents.

Insufficient attention has been paid to the transitional phase of the patient's experience. Upon discharge from a hospital, most patients experience as more or less threatening the severe cultural discontinuity existing between the hospital and the community. Much effort is needed to develop carefully graded steps for the movement of the patient from the hospital to the outside world. In the case of deep-seated chronic illness, weeks or months of arrest in various transitional phases may be expected before the patient is secure enough to resettle himself independently in the community. In this report we can do little more than mention the types of transitional facilities that may be offered:

The day or night hospital. The day hospital has been developed to allow early discharge of patients from hospital residence; however, they may continue their association with the hospital in whatever capacity is needed by returning during the day. This is especially suitable when the home environment is too difficult for the patient to endure for the full day, when patients are as yet unable to work on their own, and when long-term contact with the "therapeutic climate" is necessary. Night hospital patients work during the day but return to the hospital overnight.

The sheltered workshop. The sheltered workshop is most useful when it follows a well-developed work program within the hospital. The patient can absorb additional work training and work "hardening" in a sheltered workshop, where conditions of industry can be approached progressively.

The halfway house. The term refers to a residence arrangement, usually under the guidance of a supervising person, for patients who might profit by group or dormitory living and can earn and help pay for their maintenance. Patients who have no home to go to or who cannot anticipate comfortable acceptance at home may do very well in a halfway house.

Family care. Family care programs may be very successful, especially for chronic patients. The patient is placed with a selected family where he becomes a member who works or contributes up to his capacity. The State or philanthropic agency foots the bill, and the hospital usually maintains supervision through a social worker or public health nurse.

The ex-patient club. Patients and ex-patients have shown they are able to band together successfully in their own interest. Inpatient self-government is a gratifying actuality in many hospitals, and ex-patient clubs are increasing in number and variety throughout the country. In ex-patient clubs, former patients have an opportunity to participate in many group activities and in this way gain assurance and confidence in social situations. Club membership may be a steppingstone to developing more secure community roots and thus may play an important role in prevention of relapse.

Outpatient therapy. Therapy for outpatients is a growing service that proves invaluable to many ex-patients who need group work, long-term supportive or analytic therapy, or who require a course of pharmacotherapy or electric shock treatments. Therapy for the outpatient constitutes a major bulwark of support as well as a defense against rehospitalization.

Community adjustment becomes a natural and easy consequence of these graduated transitional steps back to society. The patient will need considerable support to withstand the stresses and slights felt in interaction with other citizens. Finding a job is often a problem because of the stigma attached to mental illness, and acceptance in the family or social group at times may be achieved only through an uphill fight. Here continued interest and support from the hospital is essential, and in some instances counseling and home visits by a trained

worker can be helpful. Often family members may be encouraged to seek psychiatric help themselves, for a patient's breakdown in many instances can be assumed to be part of a psychopathological family atmosphere. Finally, the hospital has a responsibility of educating citizens in general in problems of mental health and of cultivating good will toward both patients and ex-patients.

What outcome may reasonably be expected under good conditions of care and treatment? Although studies are still inadequate, the expectation is that of 100 acute cases admitted to an active treatment hospital, 80 to 85 will return to the community at various levels of improvement within a few months. Recent followup studies from the Massachusetts Mental Health Center show that 75 percent of male ex-patients are working full time 1 to 2 years after hospitalization. Their earnings at the time of followup equal their pre-illness levels. We know that the lives of ex-patients are often quite impoverished in the social sphere, but we do not yet have systematic data to support this knowledge. While relapses may occur in about 25 to 30 percent of ex-patients, these are often of brief duration. At 5-year followup, more than 80 percent are in the community, and roughly half of the original number have not returned to any institution for psychiatric care.

Employment for the Mentally Handicapped

An estimated 3,600 persons who had mental handicaps were placed in jobs through the State-Federal vocational rehabilitation program during the year ending June 30, 1956. These placements, 28 percent above those in 1955, included many who had not previously been employed. About 2,800 had been mentally ill, and about 800 are mentally retarded. They are among a record total of 66,273 disabled persons restored to productive lives in the public rehabilitation program in fiscal 1956.

The Office of Vocational Rehabilitation, Department of Health, Education, and Welfare, awarded about $3.2 million in support of 245 rehabilitation projects during the year, in addition to the $30 million granted for basic support of State rehabilitation programs.

Nearly 10 percent of the projects were concerned with rehabilitation of the mentally disturbed and deficient, representing a Federal investment of about $400,000.

Projects for rehabilitation of the mentally ill are operating in Connecticut, Massachusetts, New Hampshire, Vermont, New York, Pennsylvania, Tennessee, Kansas, South Dakota, Nebraska, California, and Puerto Rico. Projects for the mentally retarded are carried on in Maine, Vermont, Connecticut, New York, New Jersey, Florida, Wisconsin, Illinois, Texas, and Colorado.