PREPARATION OF PSYCHIATRIC PATIENTS FOR VOCATIONAL REHABILITATION *

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REHABILITATION counseling is one of the latter-day developments in the historical shift from permanent asylum care to the modern concept of psychiatric rehabilitation. Fundamental to this shift is the notion that the most crippling thing which has happened to the mentally ill person is that he has lost belief in himself as a worthwhile, adequate personality. In order to maintain his integrity, he is forced to develop explanations or denials of his actual feeling of self-contempt or self-hatred. These explanations and/or denials constitute part of the symptoms of his disturbance. The classical disorders of the emotions and the mind are now regarded as partly desperate stratagems which an individual plagued by self-loathing grasps in order to fend off self-awareness.

With such a view of mental disorder, a view shared in varying forms by most contemporary schools of psychiatric and psychological thought, the approach to treatment has undergone a revolutionary change. For, if part of the source of mental disorder is a lacerating doubt of one's worthwhileness and adequacy, then the treatment of such disorders must include an attempt to enable the individual to lose that doubt.

Chicago State Hospital is an "advanced" hospital in that it is oriented toward psychological reconstruction. The hospital wards or units in which the patient lives wherever possible are unlocked and the patients are given freedom of the grounds. An individual can not lose a profound feeling of incapability so long as he is not trusted to move about without restraint.

Occupational and recreational therapies, long regarded as "busy work," are pitched to encourage the individual to regain the feeling that he can "do," can learn, can make, can even play. Industrial or work assignments within the hospital, once compulsory and unselective, have been made voluntary, and the industrial therapist seeks in interviews to ascertain from the patient what his vocational interests are and what kind of work would be most beneficial to his recovery of confidence.

Patient group meetings have been established on many wards with the intention of involving the patient in a democratic management of his own living quarters. In some instances actual patient government has been instituted

* Presented at the Annual Meeting of the National Conference of Jewish Communal Service, Chicago, Ill., May 19, 1958.

This reported investigation was supported in part by a research and demonstration grant from the Office of Vocational Rehabilitation, Dept. of Health, Education, and Welfare, Washington, D. C.

whereby the granting of permission to attend classes on the grounds and to go off the grounds for the purpose of shopping, sightseeing, or job hunting, and even discharge from the hospital, are placed in the hands of a body of patients on the particular ward. Here too the premise is the same; the patient should be provided a setting in which he makes all those decisions for himself which are not incongruous with his level of disturbance.

With the hospital itself regarded as an area of intense concentration of treatment services whose aim is the restoration of confidence and the re-entry into society of the patient, attention began to be focused upon techniques which would facilitate the movement of the patient from the hospital to the community. The transitional period between the acute phase of a patient's illness and his discharge from the hospital came to be regarded as the time for his preparation for out-hospital living.

Because at each step it is the patient's confidence in himself that is at issue, techniques were developed in order to allow the individual to test himself in the outside world, and to sink new roots in it, before being required to separate from the hospital.

The notion of a night-hospital was developed. Off-grounds passes granted to the patient himself were instituted in order that he might re-establish contact with his family, re-familiarize himself with the community, and seek employment, before discharge. Arrangements were made so that the individual could begin regular full-time employment outside the hospital while still a patient. Similarly, patients were allowed to begin attendance at schools and workshops in the community in order to re-gain, or establish, marketable vocational skills, prior to discharge.

Thus the old impenetrable walls of the "asylum" even when they continued to exist physically began to melt away functionally. In their place is a kind of invisible semi-permeable membrane thrown around the hospital. The permeability of this membrane increases as the patient gradually recovers confidence and ceases to be disturbed.

An idea which gained some currency in the country was that of a vocational counselor specializing in working with those patients for whom discharge was contemplated and who wished to return to gainful employment. The writer of this paper was chosen for the post initiated at Chicago State Hospital.

At the present time the rehabilitation counselors at Chicago State carry out a number of functions all of which are pertinent to the preparation of the patient for vocational rehabilitation. They evaluate, on referral, a patient's readiness for out-hospital planning and conduct therapeutic counseling interviews in which a patient is helped to formulate a vocational plan. They carry on interim counseling with the patient during the entire period in which he is realizing that plan. They continue seeing the patient in follow-up counseling sessions for a protracted period after he is discharged.

They arrange aptitude and interest testing, supply occupational information, refer patients to in-hospital vocational training classes, refer for training to the Illinois Division of Vocational Rehabilitation, refer for placement to the Illinois State Employment Service, to private agencies, and directly to employers. They carry on concurrent family counseling, and they assist patients with out-hospital living arrangements. In addition, a carefully selected group of patients is referred to the Jewish Vocational Service workshop. It is to the handling of referrals to the workshop that the remainder of this paper will address itself.

Criteria for Selection of Cases

After a year and a half, several categories of referrals have been defined. Further additions or changes will undoubtedly come in time. For the present, the following types of referrals have been made to the workshop:

(1) *The long term patient who has been in the hospital many years* with seldom or never an off-guard pass or home visit. Visitors tend to be few. Contact with the outside world is all but lost to such a person. His job in the hospital has long since become routine. His previous work experience is too far back in time, too shadowy *to him,* to use as a current criterion for placement.

For such a patient, were it not for the shop, there would be little vocational possibility because (a) he must have some bridging experience or else he would be overwhelmed, (b) without such a resource no adequate measure of his performance potential outside the hospital could be made, and (c) few employers could be expected to hire a person with such a history without a concrete demonstration of ability to work outside the hospital.

(2) *The vocationally disabled, or disorganized patient.* This is the person whose ability to function vocationally had suffered so badly as a result of his psychological disturbance prior to his entry into the hospital that he has a real fear he *cannot* work successfully. Recall of his own work experience itself tends to excite anxiety and defeatism.

(3) *The patient who has never experienced vocational success.* Here the elaborate analysis of his performance in the work setting is invaluable whether he succeeds in the shop or not.

(4) *The patient who suffered an acute psychological collapse from which he rapidly recovered,* who before his illness was a non- or semi-skilled worker. Here the shop can become a final therapeutic tool.

(5) *The young patient whose vocational history is meager as much because of age as because of disturbance.*

(6) *The patient with a desire to upgrade himself vocationally* who is yet unclear into what field he should go or whether he could succeed vocationally.

(7) *The patient who has shown ability to work well within the shelter of the hospital* but whose readiness to work in the open market is in question.

(8) *The patient whose placeability is in doubt,* either in terms of his ability consistently to meet the minimum demands of neatness of dress, promptness of arrival, and reliability of performance or in terms of his ability successfully to relate to co-workers in a socially acceptable manner.

Among the many in the hospital who fit into these objective categories, those having the following personal qualities are selected for referral:

(1) *A self-reflective capacity;* that is, the tendency to look at and attempt to evaluate his own experience. The counselor knows that success in the shop will encourage the recovery of confidence. He also knows that unless the patient is self-reflective it would be possible for him to be objectively successful without experiencing any shift in his self-evaluation and so lose an important value of attending the shop.

(2) *Some indication that the individual includes himself as one of the causative agents in his own illness.* It has been the experience of the writer that the patient who accounts for his difficulties by means of the faults and failures and plots of others has little chance of benefiting from a referral to the shop. To profit the individual must necessarily begin with the feeling that *he* suffers from a set of work attitudes which handicaps his vocational success. Because this self-view is precisely the

one which the paranoidal, the hypochondriacal, the "pawn of fate" individual cannot adopt, referral to the shop of such a person would be fruitless even were he to accept it which, in fact, when experimentally presented, he was usually not willing to do.

(3) *Some sense of normalcy,* that is, a more or less articulate feeling on the part of the patient that he does not need to be as anxious, does not need to feel as unable to perform as he does. The individual who possesses such a sense of normalcy will give voice to it in initial counseling sessions. Such expressions as "I think I could really work well if I could get over my fear that I will make a mistake" or "I don't think I *need* to be this way" are characteristic of the person who possesses a sense of normalcy. Generically, a sense of normalcy provides a person with a feeling of discrepancy between where he is and where he thinks he ought to be able to go as a human being. The counselor listens for expressions of a normative sense because it indicates an internal motivation which cannot successfully be infused into the person who lacks it, and without which he has very little chance of success.

Of the fourteen individuals so far referred to the JVS workshop only those who have possessed these latter three qualities have benefited significantly from attendance. These people not only performed well, but also demonstrated real growth in self-esteem.

The Preparatory Counseling

The determination that the patient falls within one of the eight categories noted above is made almost exclusively in terms of what the patient tells the counselor about himself. It it generally accepted that no successful rehabilitation plan can be imposed upon a patient; rather, only that plan can succeed which has been arrived at by the individual himself. To succeed, the patient must have identified some of his own needs through the counseling process and have recognized some of his limitations.

Whatever the ultimate plan, the initial phase of the counseling experience consists in the counselor's helping the patient to sort his own pre-hospital and in-hospital experiences, relive them with the counselor, assess their meaning in the context of vocational planning, and arrive at his own conclusions about the problems he faces and his probable goal.

Little or no occupational information is supplied during this initial phase, and the counselor does not develop for the person the resources available for out-hospital training. Much time can be lost and blind alleys ventured into by a hasty offering of resources to a patient who has not yet discovered what he needs.

The possibility of attending the shop is presented only after a patient has expressed an appropriate need. The shop is not presented to persons who may appear to have the need but who do not or can not realize it.

All information concerning the person which the counselor obtains from sources other than the individual and which in any important sense alters his perception of the individual's degree of recovery or potential for vocational success is shared with the individual and the source indicated to him. To do this is to teach the individual that all of the materials the counselor will employ in working with him come either directly from him or are shared with him. The effect of this technique is to encourage the patient to feel that he is being regarded as a responsible individual and that his own concept of himself is crucial to the counselor in their planning together.

When the decision is made to offer the shop to the patient, it is described on terms as close as possible to the patient's version of his own needs. The patient is told exactly what the shop is prepared

to offer. He is supplied a detailed description of the kinds of work he will be able to try out, the nature of the observations made, the evaluation made at the completion of the diagnostic period, and the efforts made by the shop to place him in the open market if his work proves successful.

After this presentation has been made the patient is asked to consider it for a week, and in the meantime the counselor discusses the proposed shop experience with the ward physician and any other relevant staff (his social worker, his therapist, and occasionally, even at this stage, his family).

If the patient concludes that he wishes to enroll in the shop further clearance of data on the patient is made with the Division of Vocational Rehabilitation (which also conducts a personal interview) and with the Jewish Vocational Service. A counselor of the latter's staff arranges an early interview for completion of an application and a conducted tour of the workshop so that the patient may begin with concrete impressions. In the meantime the rehabilitation counselor has informed the hospital staff and made necessary procedural arrangements.

Approximately a week after the initial interview the patient returns to the shop for a day of aptitude and psychological testing. The rehabilitation counselor has already described the test experience to the patient not just as a screen for entry but chiefly as a way of developing a picture, both for the patient and for the shop, of his areas of best performance potential.

Immediately after the initial interview and again immediately after the test experience the rehabilitation counselor arranges to see the patient in counseling sessions.[1] The degree of accuracy with which the patient assesses his test performance can provide the counselor with cues to the patient's accuracy of self-perception in a current and somewhat threatening experience.

The patient travels alone to the shop for the initial interview, and every time thereafter, no matter what his period of hospitalization.[2] When he is first referred for interview to the rehabilitation counselor the same requirement is made that he come by himself. The underlying premise is that although the patient should have a bridge back to the world outside, a bridge which is firmly anchored at the hospital side, the patient must venture across it from beginning to end alone. Being escorted, even once, tends to enfeeble rather than to strengthen the growing belief in himself which the bridge is designed to promote.

The Diagnostic Experience, The Night Hospital

Inevitably, the first day at the shop excites some measure of anxiety, because the patient accurately sees the shop as a test of himself because it connotes leaving the hospital where he has experienced a measure of recovery and because leaving the hospital excites recall of those feelings and attitudes which undermined him before. If no anxiety develops one can safely conclude that the patient has not yet begun to "go" in his own terms. If anxiety does not develop at any point our experience suggests that the person

[1] This same technique of scheduling counseling sessions after each step is pursued throughout the entire rehabilitation process to enable the patient to realize and assimilate his experience while it is still fresh, by talking it out.

[2] Patients have been referred to the shop who have been hospitalized, at the time of referral as long as sixteen years. In some instances this will mean that the patient will be taking a totally unfamiliar route to a forgotten city; in others he will be traveling a route that is familiar, but which evokes painful memories of failure and fear. In all cases the patient is understood to be taking a significant step when he first ventures alone to the shop.

is too little invested in what he is doing to profit very much from the experience and he will go through the whole experience in so abstracted a state that no shift can occur in his self-evaluation.[3]

Off-grounds passes are arranged for the patient through his ward physician for a week at a time during the diagnostic program. The patient continues to live in the hospital, and arrangements are made by the counselor to see the patient regularly on Friday afternoons since the shop closes at noon on Friday. Carfare is advanced to the patient for the first week, and either money for lunch is supplied or arrangements are made with the hospital kitchen so that the person can take his lunch with him. From the second week on, however, the patient pays his own way with the money he earns in the shop.

During Friday afternoon counseling sessions the patient is asked to recapitulate his week. By so doing he is enabled to become more conscious of the nature of his unfolding experience and also to express, face, assimilate, and often rid himself of an anxiety concerning some feature of his work which had been mounting during the week.

These sessions also permit the counselor to refine or modify his prognostic impression, to facilitate the patient's efforts at self-realization to share with him any observations or concerns expressed by shop staff, and to begin discussion of out-hospital living plans.

Because of the criteria employed in selecting patients to attend the shop the counselor almost invariably recommends in his referral summary that the person be referred to the Vocational Adjustment Center if he completes the diagnostic workshop satisfactorily. In the two to three weeks of the Diagnostic Vocational Center a great deal can be learned *about* the patient in the world of work, but it is not a long enough period for the person to have learned, with any confidence, much about himself.

The referral to the shop is made to enable the patient to regain sufficient confidence in himself to successfully negotiate regular, full-time employment. Even when the patient has performed outstandingly well throughout the Diagnostic Vocational Center the counselor feels, as does the shop, that referral to the pre-placement Vocational Adjustment Center program is indicated if for no other reason than to allow the patient to consolidate the gains he has already made.

If the patient successfully completes the Diagnostic Vocational Center he begins the Vocational Adjustment Center *the following Monday morning* under DVR sponsorship. Because of this smooth method of case transfer the counselor knows from the outset that if the patient shows a reasonable potential for out-hospital employment he can have an uninterrupted workshop experience of ten to eleven weeks.

In most instances the pre-shop counseling period spans at least one month's time, usually longer. As a result, the patient usually is sufficiently well prepared for the experience to escape disabling anxiety. However, when a crisis creates an unsupportable amount of anxiety in the patient as to keep him from the shop, the counselor responds immediately to the patient with therapeutic sessions, and also interprets the situation to the shop.

The fact that individuals are referred to the workshop before their discharge makes possible close coordination and

[3] Uninvested attendance in the shop is less likely to occur when the patient has been allowed to realize its value to himself than when it is imposed upon him. A review of cases where lack of investment occurred suggests that the individual divined the thinking of the counselor and tried to please him rather than selected the shop because it had meaning for him.

flexibility of arrangements. Even poor risks can experimentally be referred.

Termination, when necessary, is a serious blow even to the patient who has responded to the shop experience with psychotic distortion. When termination occurs, the counselor relays in detail to the patient the grounds for his termination supplied by the shop, and then encourages the patient to discuss his experience in his own terms. In these cases the shop leaves open the possibility of a re-referral at a later time. The hospital counselor does not close such a case unless the patient spontaneously withdraws. In time there will no doubt be individuals who modify their crippling self-evaluations through continued counseling or intensive psychotherapy to the point where a re-referral is sound.

The Vocational Adjustment Center and Placement

Throughout the eight weeks of pre-placement experience in the Vocational Adjustment Center the patient remains on a night-hospital basis and continues his regular Friday afternoon counseling sessions. Especially during the latter period in the Vocational Adjustment Center the patient begins his final preparations for leaving the hospital. When this planning involves extensive arrangements with his family the Social Service Department is asked to join in the planning, if no social worker has been involved up to this point. In addition, the patient has regular weekly meetings with the workshop counselor who is to become his placement contact officer.

Remarkable gains in confidence often appear during this period. Anxiety begins to wane; the person's growing re-familiarity with the world outside the hospital leads him to experience a degree of impatience to be through with the shop, employed, and out of the hospital. Expressions of feeling better, healthier, happier outside than in the hospital begin to appear. Often the patient's use of his counseling sessions takes an abrupt upward turn in productivity and spontaneity. Concommitantly, shop reports often indicate that the patient is working at better levels, and that his interpersonal behavior shows a growth of ease and an expectation of acceptance.

On the completion of the 8 weeks at the Vocational Adjustment Center the avenues to placement may be through the shop counselor, state employment service, hospital counselor, or the patient's own efforts. Even when all four avenues are simultaneously being exploited placement may require from a few weeks to four months. In this period, the counselor continues to see the patient regularly in sessions which have often proved crucial in maintaining his morale, particularly as the patient experiences some rebuffs.

The length of time that the patient continues on night hospital from the point his job begins depends upon the completion of his out-hospital living arrangements, the patient's finances, his level of confidence, and his objective adequacy on the job. The counselor or the social worker makes contact with the patient's family so that they can be supportive or have a place to turn if difficulty develops.

Shortly before discharge the patient and the counselor together work out a schedule of follow-up sessions, usually to begin on a bi-monthly basis. Once all goes well on the job the counselor arranges a conference with the physician, presents all current planning, and requests the patient's discharge. Discharge occurs anywhere from two weeks to several months after the beginning of employment.

The total elapsed time between the original referral to the hospital counselor and the discharge of the successfully employed patient is never less than six

months; in one case to date it was a full calendar year. Thus a referral to the shop must be regarded as one of the most elaborate rehabilitation plans available to the counselor.

The Follow-Up

The discharged individual is maintained on active follow-up for a period of one year by the shop and for fifteen months by the rehabilitation counselor. If the person loses the job with which he began, the shop placement counselor will endeavor to find him another, as will the hospital counselor.

If periods of psychological distress occur the hospital counselor will attempt to help the patient through them. To do so sometimes involves the counselor in working jointly with the patient and his employer. In addition the Division of Vocational Rehabilitation counselor is available both before and after the case is officially closed in the eventuality that the individual needs additional training or, if he is on Absolute Discharge, psychotherapy.

Summary

It is clear in the foregoing that without the resource of the Jewish Vocational Service workshop it would not be possible to fashion, for many patients, a feasible bridge from the hospital to employment. This fact alone makes of the workshop one of the most valuable out-hospital resources available to the rehabilitation counselor in his work with patients.

Because a patient can continue to live in the hospital throughout his workshop experience it becomes possible for him to face and, at least to some degree, work through the most crippling of his responses before he is put in the position of facing both discharge and regular full-time employment. Often, the patient could not handle both at once and so would not make the attempt unless he saw that he could try himself out before discharge.

A patient is not motivated to leave the hospital until he feels able to cope with the outside world at least as well as he can cope with the hospital environment. In order to gain this feeling of adequacy on the outside it is helpful for him, before discharge, to have outside experience which he regards as successful and which has given him the sense that he could not only survive but can have an abundance in living not possible in the hospital.

This very feeling is one which we see developing in the patient who is having a successful time in the shop. Thus the shop may be the difference for a patient between shrinking from the prospect of discharge and eagerly awaiting it.

It is apparent that the workshop experience provides more than the opportunity to test vocational readiness. Because the shop is located outside the hospital the patient, in addition to having the experience of traveling to and from it, also encounters new people as counselors, shop foremen, fellow workers, and others who must be dealt with in a setting other than the hospital. The workshop constitutes, therefore, a normalizing experience, and insofar as it succeeds in this it tends to re-awaken the person's sense of the outside community. If the patient deals successfully with these many new people from the world outside the hospital, a feeling is promoted that perhaps he can make his way in that community.