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Rehabilitation – its role in psychiatry

by *M. Parameshvara Deva,*
M.B., B.S., M.R.C. Psych., D.P.M.
Lecturer
Department of Psychological Medicine
Faculty of Medicine
University of Malaya
Kuala Lumpur.

Introduction:

REHABILITATION is defined as "restore to rights, privileges, reputation or proper condition". In medicine, Hinsie *et al.* (1970) defined "the use of all medical rehabilitation as forms of physical medicine in conjunction with psychosocial adjustment and vocational retraining in an attempt to achieve maximal function and adjustment and to prepare the patient for the fullest possible life compatible with his abilities and disabilities". Essentially, rehabilitation aims at making a person function to his fullest extent following medical treatment taking cognisance of the fact of the person's abilities and disabilities. The use of rehabilitation in medicine let alone psychiatry, has only in recent times gained in importance. The preoccupation with curative and life saving medicine has been even more emphasized in the poorer developing countries where rehabilitation has taken a back seat and its formal practice regarded as a luxury that only a few large hospitals can afford on a shoe-string budget. However, with increasing success in the life saving arts of medicine and surgery, the emphasis has started to fall on the quality of medical care and the quality of after care that is so vital in the residual disabilities that persists in many patients who have been "cured". The patient who has had acute treatment may not be ill or at least seriously ill any longer but then he is not well in the actual sense either. He is therefore in a border-land that the busy hospital doctor tends to ignore and the patient tends to complain more and more about. This is the area that often requires specific attention by way of rehabilitation – the science of readjustment of the recovered or recovering person to a fuller life within the limits of his disability and ability.

Rehabilitation and Psychiatry

Psychiatry has for too long dealt with its patients by keeping them custody – not so much for the patient's treatment as a source of security for the people outside. This invariably led to institutions with inadequate facilities and overcrowded 'cells'. The quality of 'care' deteriorated to worse than that in prisons in some cases. For prisoners there was usually a limited sentence. For many in psychiatric institutions, with all their evils such a respite was non-existent. With the advent of more modern treatment methods as well as new understanding of behaviour, the need for restraints of a physical nature became more redundant in fact, even long stay in wards became less important. Electroconvulsive therapy (ECT), phenothiazines and antidepressants brought about a revolution in the thought process of the mentally ill but failed in many cases to take care of the residual disability, the readjustment to fuller functioning of the ex-psychiatric patient in society. Thousands of mentally ill no longer heard voices, stripped themselves or were violent (thanks to modern medicine) but neither were they back at their old jobs or lives in their families or society. Rehabilitation where it was sorely needed had hardly been practiced, These patients who were a liability of the institutions were now a liability of the family, the father or society.

Problems in Psychiatric Rehabilitation
Emotional Handicaps:

In medical or surgical rehabilitation, the main problems are physical, followed by psychological

and social. An orthopaedic patient who has had an amputation can hardly be successfully rehabilitated without a prosthesis of some sort. Then must come the will to accept and try the new way of life which then has to be accepted by those around him and then by society or an employer. In psychiatric rehabilitation, the physical component is superceded by a psychological one. The ex-mental patient is physically normal most often but has little drive and less motivation to do work or change. There is inertia and apathy; there is a gross lack of imagination and plenty of denial. The psychological illness has left him an emotional wreck. He expresses little feeling and less interest in anything. He may not be violent any longer but neither is he able to participate in simple tasks like going shopping or helping with housework.

Social Problems

To add to the psychological doldrums that he is in there are social handicaps. Even his own family may regard him with fear and suspicion. They have seen him 'mad' and will not take a risk in having normal attitudes to him. They treat him with caution and he reacts to this. He becomes isolated. He is seldom spoken to and he seldom talks. When he does, they talk down to him as he were a baby.

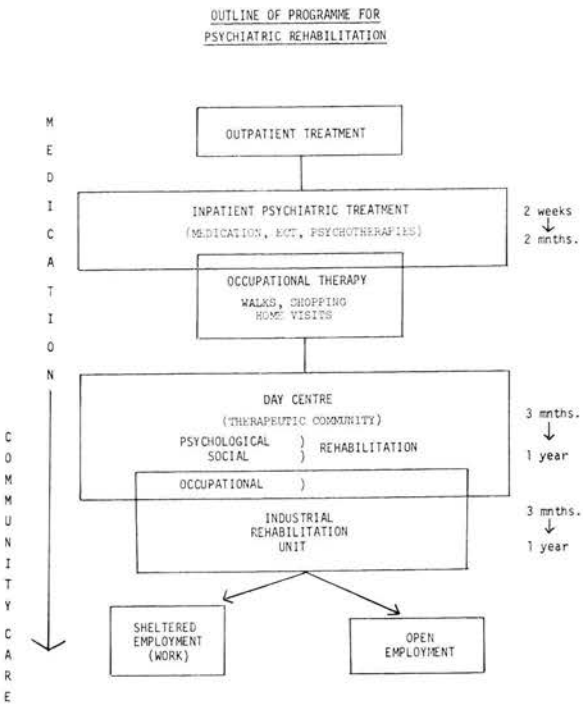

Fig. 1

Problems of Occupation

His loss of confidence, social alienation and general apathy does not help him in obtaining employing. His attitude and even his looks single him out as an 'odd' person and his chances of employment dwindle. Disappointment at job interviews have a snowballing effect on his confidence, his apathy and his social isolation. He becomes more of a recluse.

Here then, is a man who the psychiatrist says is no longer psychotic, he is not violent, he does not talk nonsense and is not hearing voices – and he is also useless in society.

A Programme of Psychiatric Rehabilitation

Any comprehensive programme of rehabilitation in psychiatry must include the three areas of deficits (psychological, social and occupational) to be effective. The programme must be tailored to fit the individual and his pace or progress of recovery.

Inpatient rehabilitation

Rehabilitation starts with diagnosis of the patient's illness, His treatment must keep in view rehabilitation needed to return him to society.

Occupational therapy should be started as soon as he is able to benefit by it and social contacts and responsibilities encouraged as early as possible. Isolation from society and dependency on hospitals easily develop with most psychotic illnesses and should be combatted by early social ambulation. Supportive group psychotherapy meetings and ward meetings are useful even in later stages of inpatient care. This part of the programme may last from two weeks to two months.

Day Centre Management

As the patient's illness improves, he may be sent on leave and his attendance at a Day Centre encouraged. Run on therapeutic community principles first postulated by Jones (1968), a Day Centre encourages patients to take more responsibility for themselves. Group psychotherapy here is more insight-orientated and occupational therapy lays more emphasis on such areas as relaxation techniques and psychodrama. Social interaction is encouraged. Behaviour problems as well as common psychological defences among members are discussed openly in the community and solutions sought out. The Day Centre in a developing country has an additional task of encouraging occupation-orientated programmes for its members through occupational therapy and sheltered workshops. Programmes here include a wide range of activities such as cooking,

group meetings, shopping and singing. Day Centre attendance is from about three months to nine months.

Industrial Units and Sheltered Workshops

Work is an essential social responsibility and an ex-psychiatric patient is seen to be still not well if he fails in the eyes of his family and society to be incapable of useful work. Patients who graduate from Day Centres successfully are then sent to sheltered workshops where needed. Here the role of the trained staff of the Industrial Rehabilitation Unit (IRU) led by the industrial rehabilitation officer (IRO) is to retrain and train the members for suitable occupations. Patients are assessed for the motor and other skills and judged on such skills as concentration, initiative and punctuality.

When they achieve satisfactory standards at the IRU, the IRO arranges for placement in suitable industry. Employment in industry may now be obtained for these patients either in sheltered employment or in open industry. The aim should however, be to seek open employment for them as far as possible; length of workshop experience varies with the individual but is usually from three months to a year. The sheltered workshop (Bellak, 1964) is like a small business and thus trains patients in all the responsibilities such as production for and satisfaction of the customer.

Medication and Community Care

The use of psychiatric medication throughout the rehabilitation programme is essential though the dosage may be reduced in individual cases as the rehabilitation programme takes effect and the patient gradually shows improvement.

Follow-up

Tertiary prevention in psychiatry or the prevention of relapses and reduction of morbidity of chronic patients demand community based treatment agencies and follow-up clinics in convenient areas in the community. Community nurses and mobile clinics can keep in touch with recidivist patients to continue medication and detect relapses early for appropriate management.

Ex-members cluns and social clubs

Many psychiatric patients who have attended rehabilitation programmes find the experience useful and tend to return to the centres to renew old ties or for advice when they have problems. Ex-members clubs channelise these needs on a regular basis and far from promoting dependency act as a community agency of help for those who need it. Ex-members clubs are informal meetings over refreshments held monthly usually with staff and ex-members to exchange views in an instructive way.

Summary

The three aspects of psychiatric rehabilitation i.e. psychological, social and occupational rehabilitation are interrelated in their common aim. The recovering mentally ill patient is hardly a patient who is well and rehabilitation forms an integral part of management in psychiatry. A wide variety of therapies are available for patients who need psychiatric rehabilitation.

Conclusion:

The age when psychiatric treatment constituted of locking the mentally ill in cells is hopefully past. The present emphasis on short stay general hospital management of acutely disturbed behaviour in mentally ill patients is deficient in its long term care of patients. What is needed is a comprehensive short-term hospitalization and longer term rehabilitation for psychiatric patients in therapeutic communities that aim at discharge of the mentally ill fit to take their rightful place as responsible people in society.

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