

Experiences in rehabilitation of chronic schizophrenic patients

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To try to communicate experiences in or views on rehabilitation of specific groups of patients, makes it necessary to present simultaneously the situation from which these experiences are drawn.

My experiences are gathered from working in the central psychiatric hospital of Oslo, Dikemark. Oslo is the seat of administration in Norway, and industry is an important source of income. The patients are patients in this hospital, a hospital where dynamic socialpsychiatric points of view are emphasised. We are adequately staffed, partly by people with extensive training and experience in psychiatric treatment. Oslo has a well developed outpatient psychiatric service and hospital treatment is only one among several treatment services offered. The section for women, where I work, has 350 beds at its disposal, divided upon 4 subsections, with specific work areas, each subsection headed by a clinical director.

In addition we have for the last 15 years steadily expanded our own out-patient section, our pre- and after-care department, in the city. Last year 800 female patients were treated with a total of 9.000 consultations. In addition we have visits to the patients' homes, conferences with people closely connected with the patient, social gatherings, clubs and industrial therapy. The treatment includes analytical oriented individual therapy as well as social therapy, especially longtime supportive therapy. The after-care department also has two after-care homes with a total accommodation of 20 patients.

Schizophrenic patients and the "total treatment programme"

In the following I shall concentrate on the experiences we have gained from patients diagnosed as schizophrenics, mostly of long duration. This

group of patients is no longer dominated as it was formerly by chronic patients with dementia and bizarre behaviour. On the contrary our present main problem is patients who have suffered a schizophrenic psychosis and who are discharged after a relatively short period of treatment in the hospital, but who will continue for a long period of time to have the handicap to be especially vulnerable in specific situations of stress. These patients we will continue to meet in the after-care for a long time after their discharge. Most often they come at intervals of weeks to months, but then something occurs that activates their particular pattern of reaction and makes more intensive treatment necessary for a while.

Today we are treating 275 patients with this diagnosis, 180 as outpatients and 95 in the hospital. Around 60 % of the patients are under the age of 50, and consequently current candidates for rehabilitation. Approximately every 4th of these are supported by their relatives, the rest are obliged to manage on their own or by help from society.

Every year between 15 and 20 patients in this age group and with this diagnosis are admitted to the hospital for the first time, and with the experiences we have had so far concerning the total amount of time for treatment of these patients, we have to face the fact that this problem will still continue to demand our attention.

Our total treatment programme, the combined hospital- and out-patient programme, is grown out of the requirements our patients have shown, and rehabilitation problems have definitely played an important part in the way we have developed our work. We regard rehabilitation and treatment as two functions, each has its own specific importance and must follow a parallel course depending at all times upon the requirements of the single patient. The treatment layouts are worked out by

physician and social worker in collaboration with the rest of the staff.

We carry out, as far as it is practically permissible, a continuity of treatment. The patient is kept in contact with and treated by the same team in hospital as in the outpatient department. This way we make sure of the best possibilities for integration of experiences.

The period of hospitalisation for schizophrenics today is relatively short, by 3 months after admittance, 60 % of the patients have been discharged, subsequent to 1 year after admittance only 20 % are still in hospital. We deliberately stake on shorter stay in hospital because a prolonged absence from the patient's actual environment and the difficulties the patient must be prepared to meet, sometimes tends to obscure the real problems and makes a realistic evaluation of the patient's potential more difficult. Shorter hospitalization also reduces the danger of hospitalization artefacts, secondary dementia, extreme dependence, a tendency to regression and social isolation.

But the shorter time of hospitalization must not make us disregard the requirements for activism and rehabilitation. The patients have often been ill for a long time before the actual admittance takes place, and the social and occupational level of functioning may have been reduced over a period of time.

Right after admittance, while the symptoms still characterize the patient to a high degree, psychiatric therapy and drug therapy will be the primary treatment. Through the contact established with the patient by occupational therapists, we might from the very beginning get the patient to participate in different activities determined by the clinical condition of the patient. Some of these activities aim towards helping the patient to acquire better understanding as a part of psychotherapy. Other activities primarily aim at keeping the patients occupied, with the intention of observing their activity and interest level, maintenance of and training of more vocationally guided specialities such as house work, office training, hair-dressing etc.

The patients join in the daily routine in the

wards as a part of the activity programme, but we have also a small domestic science course headed by an instructor, who personally is an experienced, well educated psychiatric nurse as well as a happy housewife. She has undoubtedly just by being the person she is, given many a worn out housewife new courage, and many a young girl a different view on housework not because culinary refinement is emphasized but because she regards housework as an occupation where economy and the ability to organize give good results.

The rehabilitation ward

This form of activity-saving rehabilitation will for a greater part of our patients be sufficient to make the patients function in society. It appears, however, that we continually have groups of patients where these efforts are insufficient, who do not manage to function according to what is demanded of them. This group might not be numerically large, but the further rehabilitation efforts they require are time consuming and require a relatively large and specially educated staff.

We have chosen to concentrate this work in a special section, which in its structure and staff aims towards solving the problems of these specific patients. The therapeutic work here is concerned with two main tasks, make sure conditions are right for a best possible observation of the preserved level of functioning, from these observations to help the patients toward better functioning and adjustment.

Man should never be viewed isolated from his environment, and we regard it equal important to help the patient towards greater tolerance towards fellow man, towards better contact and better patterns of reactions as towards vocational training and education. The section is structured on the principal of therapeutic community, and the treatment is built around group activities adapted to the requirement of the patients and the ward.

Part of the day is spent in the industrial training unit that belongs to this section, and the experiences from the work situation are discussed by the patients and the staff, all of whom have at some time been engaged in this particular work setting,

and who can therefore participate on a realistic level.

In this section we are especially occupied by research programmes, by finding means to register the observed material, and have, among other things, found out an autocharacterisation form that all patients at intervals are encouraged to fill in, where we get an impression of how the patient looks upon himself in relation to the outer world, and how this outlook changes in the course of the treatment.

One of the most important objections that may be raised against our rehabilitation layout, is that it is not realistic enough. The patients must necessarily be appraised in the situation they themselves and the observer happen to be, namely an institution, and we have consequently found it necessary to continue the programme from the rehabilitation unit in the hospital to the treatment programme after discharge in the after-care.

Rehabilitation hostels

If we have doubts in regard to whether the patient is able to face the outer world, or if she would be better off being more gradually adapted, we have the facilities to try this out in one of our after-care homes, which offer different forms of milieu-protection.

In one of the homes where the patients sometimes stay as long as 1—2 years, they'll get their room and board. The staff, however, has no special psychiatric training and has small possibilities of being able to cope with special problems that might arise.

The other after-care home has a well trained psychiatric staff, and here every-day problems that the patients might meet in society are at intervals discussed in group meetings. The staff is always prepared to discuss individually with the patients the problems they meet in their daily struggle for adjustment, at work, in contact with their employers, at school or in other situations.

What are the specific problems that our outpatients present to us?

I will again return to female schizophrenic patients

below the age of 50. We learn that 20 % has social pension while 80 % have gone back to work, either in their own homes or to some other employment. Office, domestic or restaurant-work seem to be the most common, why only few seek employment in industry. There might be a variety of reasons for this, but the most common seems to be the long work hours, the hard pace and the small possibilities for part-time employment.

The patients' ability seems to fluctuate according to the security the patients feel at all times. Therefore many patients want to continue to use ataraxica even when this is no longer considered necessary, because it gives them a feeling of being able to face the strain and problems of an ordinary life. These are of different kinds, change in employment situation, increase of pace, or an advancement. The reactions of some are hallucinations or slight ideas of reference, while others more frequently perhaps, have thinking disturbances, a feeling of emptiness and vagueness of ideas. For some patients these symptoms are an additional load they have to carry, that makes their daily workday a strain that demands everything they have to give. The patients feel worn-out, and have no incentive to go out and see other people. This tendency to isolate again increases the danger of relapse.

For the benefit of these patients we have established social clubs where they have the opportunity to meet informally with other people with the same problems. Through these clubs they might also get the opportunity to participate in other activities that seem adequate or sufficient for their particular ability to make contact with other people, as visits to the theatre, trips abroad, discussion clubs etc.

One of our most important problems is the social isolation that somehow is a result of the social security pension some of our patients receive. They do not have to work, and one day seems just so gray and monotonous as the other. We have been forced to face their problems, because it is one among other causes for relapse and lack of adjustment, and formerly also for readmittance into the hospital.

We have established a training programme for these patients. First they participate in social group gatherings, next they have a hobbylike occupational therapy and finally sheltered workshops.

What advantages do we feel that our specific form of rehabilitation includes? By incorporating the rehabilitation programme within the hospital area, we think first and foremost that we have time on our sides as a very valuable ally, instead of a very effective enemy. We have, through our contact with the patients, gained a thorough knowledge, not only of the patient herself but also of the patients family and her closest environment. Consequently we feel that we have the best possibilities to work through with the patients their reactions as they occur and direct therapeutic measures where needed.

Some concrete rehabilitation problems

One of our main problems that directly counter works effective rehabilitation is the shortage of housing, that prevents the patients to be discharged at the most opportune moment in regard to rehabilitation and therapy. We need ordinary housing as well as more or less sheltered housing.

We also lack the possibility for training the patients for special vocations and specific work areas. I feel, however, that this is outside the field of the psychiatric hospital. On the other hand I believe we must be willing to and free to offer our help to the patient and the rehabilitation institution in the subsequent phase through our after-care.

We also lack the opportunity for sheltered work for the patients who do not manage to face the problems on the open work market, places of work where necessary consideration is taken of the patients' variable conditions and specific patterns of reactions. We do have concrete plans for such places of work, and the waiting list already has more than 50 names.

Finally, and probably most important, do we lack the possibilities of a truly realistic estimation of the particular patient's capacity and level of function, and possibilities for appraisal of the specific assets or deficiencies of the patient. Here there is a demand for and room for research and intensive observation and collection of material to gain a better understanding of these problems, which, in my opinion, will surely characterize some of the future work in the field of psychiatry

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att inom rehabiliteringsteamet svara för socialmedicinska utredningar och åtgärder samt kontakten med postverkets personalvårdsorganisation i övrigt. Verksamheten motsvarar den som bedrivs vid en medicinsk rehabiliteringsavdelning.

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UPPLYSNINGAR

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