WORK CAPACITY SEEN FROM A PSYCHIATRIC VIEWPOINT[1]

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ABSTRACT. My viewpoint is based upon my experience from the National Clinic for Assessment of Work Capacity. When judging the working-capacity one has to consider not only the patient's somatic and mental status but also his social environment, i.e. possible social and geographic obstacles. The relation between these different factors is never static. There is always a dynamic interplay between these factors. Especially, the psycho-social situation often changes during the rehabilitation-process.

The patient's motivation on going back to work often under worse economic conditions—owing to illness/injury—seems to be connected with his capacity for a new way of living. In the psychiatric judgment of the patient's working-capacity it is desirable to let go the conventionally diagnostic way of thinking and concentrate instead on a differentiated judgment of the patient's psychical resources together with limitations of his personal integrity and intelligence. The goal must be to help the patient making full use of his psychical energy for a readaptation to work.

An assessment of the work capacity of a relatively complicated clientele is being carried out at the National Clinic for the Assessment of Work Capacity. Experience has shown that about 70–80 per cent of the patients have psychiatric problems that complicate their placement in jobs. In 30–40 per cent of the patients mental disorders are the main obstacles in work adaptation. These figures are not remarkable compared with other handicap groups in vocational rehabilitation.

A superficial analysis of such a patient—for example, by the referring physician—may suffice to recognize the somatic handicap of the patient —an amputated limb, a hand disability, spinal insufficiency, etc.; but a more penetrating analysis is called for. In our experience it is of the utmost importance to observe the patient in the workshops; this will often disclose that the real problem lies in mental difficulties in adaptation, lack of stamina or a slow rate working.

An attempt should always be made to see the patient *in toto,* by giving consideration to the somatic and mental status, the social environment and the "geographic factor", which takes account of, for example, the local opportunities for suitable employment.

A rehabilitation process after an illness, an injury or some other incident in the patient's life that suddenly deprives him of his ability to work is often a long one, where a variety of factors are operating at different stages. Rehabilitation must be looked upon as a dynamic process, in which it is essential to consider the patient's resources—intellect, special talents, strength of will, etc. One must, of course, also bear in mind the patient's limitations as regards, for instance, motor function. There is therefore need for strong action—motivation—on the part of not only the handicapped person to be rehabilitated, but also of the team that is helping him. A narrow, conventional approach can hardly be expected to produce beneficial results. A psychiatrist may well often feel helpless if constrained by the bonds of classical concepts as psychopathy, alcoholism, psychoneurosis etc. A new view on the patient is needed, where consideration is given to the factors mentioned above.

I feel that what makes a rehabilitation successful, a rehabilitation that gives full and meaningful support to the patient—are factors that are dependant not so much on any somatic handicaps, neurotic symptoms, mental characteristics and so on, but rather on willpower and the ability to achieve a new orientation in life. This energy that can be used in securing an adaptation to work cannot be created with the help of diagnostic

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forms; the steps necessary to get the patient to exploit his resources for social adaptation are not always found to be consistent with the usual therapeutic measures applied at mental hospitals.

Our experience indicates that there are often minor events, measures during the rehabilitation process, that may be the crucial factor in getting the patient to cooperate in the rehabilitation scheme, where he had previously offered passive or active resistance.

The experience of finding something in common with other handicapped people can sometimes be of decisive importance; again, the community may, through the rehabilitation team, give the patient financial support, help in obtaining a driving licence, an invalid car, dental care, accommodation or anything else of significance at a particular time.

From the group therapy meetings that I have arranged during the last 6 months at the Clinic, I have the impression that it is essential that the patients should feel that one wants to help them—no doubt because the person with a handicap in one way or another feels outside society or at best on the edge of it. Because of this, if he does not have the sense of cooperation with the therapeutic team, regression may easily occur and lend to infantile defiance reactions. It was surprising to see how the work motivation improved when the patient had the possibility of verbalizing his feelings of frustration and anxiety within the frame of group therapy.

It may be as difficult to manage these tendencies for regression as it can be to deal with unrealistic claims of vocational choice, whether these are due to lack of insight caused by illness or a parasitic tendency to take advantage of the handicap to get social benefits. Such traits in the patient undergoing rehabilitation may call for time-consuming therapeutic measures.

The selfrespect of many patients is impaired in connection with illness or the injury that is the reason for the rehabilitation. In many of the most serious cases the selfrespect has never been particularly strong, and it is then important to help the patient towards a certain feeling of security while at the same time trying in various ways to build up his selfesteem.

The goal in rehabilitation should be to get the patient to assume responsibility for himself with realistic insight, to realise his medical limitations and society's possibilities of helping him according to his handicap, which in reality may not be so great.

A rehabilitation programme naturally often calls for considerable adjustment on the part of the patients' family and this should be borne in mind in judging the patient and in deciding the practical work concerned with his psychosocial re-education.

It is thus essential when rehabilitation is considered to obtain a thorough medical and social analysis of the handicapped person and his family, and of the resources the society has to offer that can be of use to the patient.

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