Psychiatric Approach to Mentally Disordered Employees at the Workshop

Michio YAMADA, Tamio OTA,
Taku SHIGEMOTO, Junro FUJITA,
Kazuo OTSU* and Hiromichi MIMAYA**

Department of Neuropsychiatry, Yamaguchi University School of Medicine, Ube
**Department of Neurology, Yamaguchi Rosai Hospital, Onoda*
***Onoda Shinwaen Hospital, Onoda*
(Received August 5, 1977)

INTRODUCTION

The status of psychiatry in industry or enterprises has not as yet been established fully today. Presently, industrial and occupational psychiatry is barely functioning as a sector of curative medicine in a part of the major companies, and its results in the preventive field are scanty.

Since the early 1950's, when neuroleptica and psychotropic drugs were introduced as treatments for mental disease, many mentally disordered people have been released from treatment employing longterm, futile isolation, and have been integrated into a normal social life while receiving treatment. Thus, psychiatry has begun transforming itself from a curative science to a preventive one.

The following are factors which prevent the establishment of psychiatry in companies amidst progressing current of psychiatry. Naturally, companies have as their first objective the seeking of profits. To achieve this aim, disruptions of human relations, are avoided through safety precations, and accident prevention measures. On-the-job psychological treatment has not been a part of such objectives. However, the therapeutic activities of psychiatrists in companies aim at protecting the interests of the patients, that is, promotion of therapy, with the significance of occupational therapy, and prevention of financial breakdown of patients and their families.

In the past, as late as twenty ago, Japanese companies were concerned about profits to the exclusion of the employees mental health. Only recently has this conflict of interest between business and psychiatry

been resulved.

In a production plant with 3200 workers that started operation in 1955, a mental health , are plan was created as a part of that companie's health care. With the cooperation of a clinic associated with the plant, and a division of the Department of Labor Safety called the "Health Care Center", the "Mental Health Clinic" was opened in 1972.

We shall summarize our experien, e for the four years from 1972 in this report, which we hope will serve as a milestone for our future activities.

RESULTS AND DISCUSSION

1. Situation in the occurence of mental disorders:

The number of persons with mental disorder we had encountered, totaled 33 when the term mental disorder was broadly interpreted to include patients with neurosis. The incidence was about 0.10 per cent, which was considerably lower than the result in a similar report (0.34 per cent; Haruhara et al.[1]).

Of the 33 patients, schizophrenics were most numerous with 13. Of them, 9 were discovered when they were examined for consideration for reinstatement (Table 1).

6 of these, 9 schizophrenics were discovered in 1972 when the clinic was first opened (Table 2).

Their abnormal behavior included symptoms considered deriving from pathological experiences, such as delusions and hallucinations, as well as, psychomotoric excitement and displays of abnormal volution and

Table 1. The course through which to find mentally disordered persons

Motive for taking medical examination / Diagnosis	Advised by workshop to take medical examination	When examined for judgement on reinstatement	Requested by family members	Medical examination taken voluntarily	Total
Schizophrenia	3	9	1		13
Neurosis				7	7
Epilepsy	2		1	1	4
Affective disorders	2			1	3
Borderline case	1			2	3
Chronic alcholism			1		1
Psychogenic reaction	1				1
General paresis				1	1
Total	9	9	3	12	33

Table 2. The number of persons who took the first medical examinetion by year

Diagnosis \ Year	1973	1974	1975	1976	Total
Schizophrenia	6		4	3	13
Neurosis		2		5	7
Epilepsy	1	2		1	4
Affective disorders	1		1	1	3
Borderline case				3	3
Chronic alcoholism			1		1
Psychogenic reaction		1			1
General parasis		1			1
Total	8	6	6	13	33

Table 3. Abnormal behavior questioned at workshop

Diagnosis \ Behavior questional	Violence	Weird act	Absence without leave	Work efficiency lowered	Work under influence of liquor	Clouding of consciousness	Miscellaneous	Total
Scrizophrenia	1	8	3	1				13
Neurosis			1	3			3	7
Epilepsy	1					3		4
Affective disorders	1			2				3
Borderline case				3				3
Chronic alcoholism					1			1
Psychogenic reaction		1						1
General paresis								1
Total	3	9	4	10	1	3	3	33

emotion on the job. This behavior prompted their medical examination. Type of abnormal behavior which pose a problem in industry are shown in Table 3.

Neurotics are not mentally disordered persons in the narrow sense of the word, but are often evaluated as being persons maladjusted to the workshop. Most of the 7 neurotics studied had developed obsessional and anxietal symptoms following a re-shuffling of the personnel at their job site. Such incidents, as well as promotons and accidents trigger such symptoms. Such cases categorize neurotics as unifit or maladjusted to normal working conditions.

Unlike the schizophrenics we treated, the neurotic patients all went to the clinic for examinations on their own initiative (Table 1).

Also, it is interesting that whereas the cases of schizophrenia decreased in number as the clinic gradually established itself, 5 out of the 7 neurotics were examined at the Mental Health Clinic in 1976 when the activities of the clinic were well established (Table 2).

A similar tendency can be seen with patients coming under the heading of borderline cases.

Of the epileptics, 1 is a traumatic epileptic, 1 has temporal lobe epilepsy and is in a dream-like state, and 2 have episodes of dizziness as their chief symptom. In all these cases clinical symptoms were well controlled by the administration of anticonvulsants.

Of the patients with affective disorders, 1 case was typical of the chronic manic and 2 cases, that of depression. Depression, in these 2 cases, had a strong tendency toward neurotic depression.

1 case of psychogenic reaction presented manifestations such as a hyperventilation syndrome triggered by accident at his workshop, but after several sessions of counseling, his condition rapidly improved.

1 case of general paresis, concerns a person who had received treatment for it in the past. He came to clinic for reexamination and was found to have a speech difficulty, a decline of intelligence, etc. He has been transferred so that his duties entail only light work, and observations on his clinical couse are under way.

There was only 1 case of chronic alocholism. This figure is considerably small, contrary to our expectations, when consideration is given to the number of workers present. According to information hitherto available to us, presence of another alcoholic patient is confirmed, but we have failed to place him on therapy. In this particular company, the management had been relatively lenient about drinking liquor off-the-job. There was an attitude in which drinkers were left alone, unless they worked under the influence of liquor, or were absent from work repeatedly due to their drinking habits. We believe that this had something to do with such low figures.

2. Treatment of mentally disordered persons:

Schizophrenics received either in-patient treatment or out-patient treatment at a mental hospital, and the Mental Care Clinic at work, according to the severity of their symptoms.

As to patients receiving treatment at the mental hospital, we made efforts to grasp their clinical course through close contact with the physician in charge and discussions with people involved with the patient at work as well as the patient's family. We wanted to find out what set off their schizophrenic episodes and the various measures taken for their reinstatement to work, such as charge in the pattern of work, job

category and timing of reinstatement.

In conducting pharmacotherapy in the treatment at the Mental Health Clinic, we made it a rule to administer drugs once a day and to provide a drug holiday. This appears to be helpful in preventing the "revolving door syndrome" (Ayd[2]).

Further, we asked the patients' family members to visit the Mental Health Clinic periodically. We felt that cooperation of the family members was essential for the treatment of mental diseases that usually persist over a long period of time.

However, when a patient was unmarried and lived in the company dormitory, it was very difficult to find members of the patients's family who had a deeper understanding of the patient, or to coordinate the home enviroment with the treatment at the clinic. Such difficulties often make treatment less satisfaction[3].

For epileptics, changing their working place to one free of danger was carried out. For neurotics, emphasis was plased on the coordination of personal relations. Counselling or administration of psychotropic drugs proved effective in about half the cases of neurosis. In such case of neurosis, the working environment was theoretically unaltered, but knowledge of the patient's psychological treatment undoutedly affected the attitudes of fellow workers toward him.

3. Reinstatement of mentally disordered persons:

The rate of reinstatement for the mentally disordered workers is high at this workshop. Only 1 of 13 patients have resigned since we started health care there. 2 are presently receiving hospital treatment at a special hospital, 1 is receiving home treatment, and 9 have already been reinstated.

For reinstatement, a meeting consisting of the patient, his family, his superior, a psychiatrist, the person in charge of personnel affairs at work, and staff members of the Health Care Center, is held to decide on an appropriate course of action.

In such cases, the desire of the patient, and the goals of the workshop are coordinated on the basis of a report and medical certificate made out by the physician in charge on the patients therapeutic course, and a written opinion by a physician of the Mental Health Clinic.

We see to it that the patient, in principle, returns to the same workshop that he worked at before his suspension from work. The working hours and work volume, are decided with full consideration given to the patients' mental hygiene.

In the case of incomplete remission, it is sometimes undesirable to have the patient return to the workshop he worked at before his suspension from work. We engage such patients in gardening work, such as tree planting, weeding, and watering, or cleaning work as an indicator of his working potential. 6 schizophrenics received such work assignments. Of them 4 were later able to return to the workshop he used to work at before his suspension from work, three months to one year later. Such a trial is institutionalized in the form of trial reinstatement and protective workshops, in a few large enterprises. In this case, however, there are problems as to the wage and guarantee of the status of patients (Haruhara[1]).

On-the-job occupatioal therapy, as described above, is expected to produce many good results, but it is influenced by the quantity and quality of the leaders, and also holds the danger that being a member of such a group, in itself, creates in patients an inferiority complex.

As to the guarantee of their status, things generally go well. They are treated as a normal staff member at the workshop that they worked at prior to their suspension, but their wages are reduced slighty, and overtime allowance, and dangerous work allowance are not paid to them.

Out of 9 reinstated persons, 2 are evaluated as having adapted themselves excellently, 2 good, 2 adapted albeit with some problems, 2 poorly and 1 very poorly. The 3 persons evaluated as poor, or very poor, all live alone in the dormitory or have no guardian near by. In the latter case, family members who could share a part of the responsibility for the treatment of the patient live too far away to be of use. This is also pointed out by Fujii[3] as posing a major problem in patients returning to society.

4. Early discovery of mentally disordered persons:

It is by no means easy to discover mentally deseased persons in groups of people. Take, for instance, the Cornell Medical Index (CMI), which is given to all persons entering a company. It is employed here, and we take part in the panel for assessment. The health questionnaire is ineffective in detecting schizophrenics in many cases, since the possibility of intentional distortion by the examinee is high, as has hitherto been pointed out (Konishi[4]). As a matter of fact, results of CMI done previously to patients place under our psychiatric control were all within the normal range.

For the purpose of screening mentally disordered persons at the place of employment, we are now studying the adoption of a scale, in which abnormal behavior often shown by mentally disordered persons are enu-

merated, that is, compiled in a type of check list (Haruhara[5]). This is not a scale which distinguishes poeple with mental disorders, directly, but one in which a range of observation, and points to be taken note of, are given. We intend to use this check list for educational training concerning mental health. We keenly feel the necessity to educate comany supervisions on the subject of mental hygiene and we are therefore planning to implement it shortly.

We also understand fully that psychoses and those suffering from it are not the only major object of mental health care.

5. Future of the mental health clinic:

In engaging in the activities of the Mental Health Clinic, we take utmost care not to report any information we have obtained from patients per se, to the persons concerned at their workshop, particulary those in charge of the personnel affairs.

As to the legal basis for such privacy, though not specifically, mention is made of the provisions for leakage of secrets by physicians under Article 134 of the Criminal Code, and provisions for preservation of secrecy concerning health examination under Article 104 of the Labor Safety and Health Act. We firmly believe that this preservation of secrecy and our attitude of sympathy with the patients in our activities are very important in the management of the Mental Health Clinic.

This appears to be reflected in an increase in the number of workers within the bounds of the possibility of having neurosis, voluntarily submitting themselves to examination, and an increase in the number of cases where families of workers ask for advice on mental disorders, with 1 case in 1974, 3 cases in 1975 and 5 cases in 1976.

Table 4. Period from onset of disease till medical treatment received

Diagnosis	Before health care					After health care		
	−1 month	−6 months	−1 year	1 year−	Tota	−1 month	−6 months	Total
Schizophrenia	1	5	5	2	13	10	1	11
Neurosis	1	1	2	3	7	1	1	2
Epilepsy		1		3	4	3	1	4
Affective disorders	1	2			3	1		1
Borderline case		1	2		3			
Chronic alcoholism				1	1	1		1
Psychogenic reaction		1			1			
General paresis				1	1	1		1
Total	3	11	9	10	33	17	3	20

We are continuing our activities partly in an advisory role as designated by the employer, and partly physicians, from the standpoint of the patients. In such a situation, we are required to take a cautious attitude so that our opinion may not be exploited by either the entrepreneurs or the workers. The role of a psychiatrist in the company is to help in the social and legal obligations and responsibility of entrepreneurs and workers, but he cannot, and should not, shoulder the entire responsibility on their behalf (Sekiguchi[6]).

As shown in Table 4, the time required for a patient to be placed on medicare, in case of recurring symptoms, is shortened since we started engaging in such treatment.

With such cases as cited above, we should on no account take the standpoint of administration, management or control.

We will make efforts to establish psychiatry at the place of work from such a perspective.

SUMMARY

We have reported our experience with activities in a mental health clinic at a certain production factory (about 3,200 workers).

Mentally disordered persons we had treated during four years from 1972 to 1976 numbered 33. They were broken down to patients with schizophrenia, 13, neurosis, 7, affective disorder, 3, borderline cases 3 and chronic alcoholism, psychogenic reaction and general paresis, 1 case each.

We have discussed the usefulness of the activities of the mental health clinic at the workshop on the aspect of reinstatement of mentally disordered persons and other relevant questions.

REFERENCES

1) Haruhara, C.: Problems on mentally handicaped at the workshop. (in Jap.). *Psychiat. Neurol. Jap.*, 69 : 907–914, 1967.
2) Ayd, F.J. Jr.: Fluphenazine enanthate. *Int. Drug Therap. Newsletter*, 1 : 37–40, 1966.
3) Fujii, H.: Treatment for mentally disordered at the workshop. (in Jap.). *Jpn. J. Clin. Psychiat.*, 5 : 151–158, 1976.
4) Konishi, T.: Experience of CMI to industry employees, (in Jap). *J. Ment. Hygin.*, 1 : 28–35, 1968.
5) Haruhara, C.: *Mental hygine in the workshop.* (in Jap.). Igaku-Shoin, Tokyo, 1971.
6) Sekiguchi, K.: Psychiatric care to mentally handicaped employees at the workshop. (in Jap.). *Jpn. J. Clin. Psychiat.*, 5 : 167–174, 1976.