VOCATIONAL ASSESSMENTS OF PSYCHIATRICALLY DISABLED PROFESSIONALS

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ABSTRACT: The onset of psychiatric disability in middle life and its disruption to the careers of professional women and men has not been adequately addressed in the psychiatric rehabilitation literature. Each year thousands of individuals become victims of major affective disorders or psychotic illnesses causing manifold deterioration to their functioning as successful physicians, dentists, lawyers, teachers, nurses, etc.

Vocational assessment becomes a crucial service for these victims of mental illness. At McLean Hospital, a private non-profit psychiatric hospital affiliated with Massachusetts General Hospital and Harvard Medical School, the Rehabilitation Services Department has been working on a series of standardized tests, simulated vocational experiences and rehabilitation counseling techniques to determine feasible occupational alternatives to these former well-established professionals.

This presentation will highlight the vocational assessment process by illustrating in depth three professionals admitted to the hospital and their subsequent outcomes.

This paper will attempt to identify some major themes, problems, resolutions and outcomes of three professional people who became mentally ill in their adult years. The vocational assessment process in each case developed along unexpected lines and directions, mainly due to the severity of the illnesses and the unique psychological make-up of each patient.

Botterbusch refers to six critical areas when evaluating disabled persons. He begins with a complete case history that consists of personal, education, employment and medical histories plus a description of present activities. Next, he identifies physical and psychomotor capacities, underscoring the importance of quantifying physical capacities as much as possible using accepted DOT definitions. Academic achievement, aptitudes and vocational interests comprise areas three, four and five. His last category for consideration is entitled psychological and emotional stability. This he identifies as the most subjective of the six areas and therefore, the most difficult to evaluate.

Indeed, assessing the functional capacities of formerly high-level professional dentists, doctors, lawyers and research chemists after they have experienced the dramatic onset of a major affective illness or psychotic decompensation becomes a process of relative objectivity in relation to the subjectiveness of emotional and psychological stability.

McLean Hospital, a private non-profit psychiatric hospital is located in Belmont, Massachusetts, a suburb of Cambridge and Boston. It was established in 1811 by the Massachusetts General Hospital Corporation and maintains a close affiliation with the Harvard Medical School. As a teaching and research center, McLean services patients from many parts of the world and often receives referrals from private psychiatrist who treat professionals from all disciplines in academia and corporate structures.

At the time of my initial contact, Dr. A. had been previously hospitalized on three occasions dating back to nine years. His initial age of onset was twenty-eight. At that time, he was serving in the U.S. Navy, becoming grossly psychotic aboard ship on his way to Viet Nam. His mental status on admission to the U.S. Public Health Hospital was one of confusion, rambling, non-sensical talk, fearfulness and loose, unintelligible thoughts and speech. He was treated with anti-psychotic medication, electro-shock therapy and recompensated fairly quickly. He received a medical discharge from the Navy, went into practice as a dental associate and soon opened his own practice. Despite on-going pharmacological and psychotherapies and two subsequent hospitalizations, he continued to practice, receiving a great deal of support from his sister who doubled as his office administrator. When his sister married and had her first child, leaving Dr. A. for a maternal leave of absence, he exhibited strange behavior in the office. He was abusive and inappropriate to his patients, inconsistent with his appointments when he was able to keep them and gradually decompensated to the point where his parents called the police to admit him involuntarily into McLean Hospital.

His course of hospitalization was highlighted by medication changes and alterations to respond to his manic-depressive fluctuations. Psychological and neuropsychological assessments revealed full scale I.Q. between 90 and 95, memory function in the borderline to dull normal range, severe cognition dysfunctioning in the areas of concentration and task maintenance and an inability to reliably produce a three step motor program. His CT Scan revealed a minor abnormality reinforcing the neuropsychological results of cortico dysfunctioning in the frontal and temporal lobe area.

His mental status during this period indicated that he could not tolerate ten minutes of sustained vocational exploration due to preoccupation with his bowel and bladder control and his overwhelming embarrassment and fear of being any distance from a bathroom. In addition, he was obsessed with the effects of the medication on his life. He would complain endlessly about his inability to resume his practice yet acknowledge the current realities of his debilitated state. Another major theme of our meetings was his ever-present frustrations in relation to his social life.

Much of his attention was legitimately diverted to his body because of the medications he was taking. Periods of blurred vision, finger and arm tremors and leg trembling contributed to his inabilities to sustain concentration and produce activity of any nature. His attempts to receive greater disability benefits from the Veterans Administration added to his frustrations to the point of applying to Social Security for disability assistance. In December of 1983, he was denied benefits and a secondary appeal application was made with this writer summarizing the above-stated information with this concluding statement, "Dr. A.'s attention span is severely limited as he is unable to focus on constructive work activities outside of his own bodily needs. I am very pessimistic about his prognosis to return to his dental practice and currently feel that he is limited to the minimum functions of activities of daily living."

Dr. A. received approval of his appeal application in February, 1984. He continues in a community mental health center day treatment program five days per week and is maintained on Lithium Carbonate and Tegretol.

Dr. B. was born in 1931 in Brooklyn, New York, the older of two boys to a hard-working garment cutter father and a chronically ill mother with long-standing cardiac and diabetes problems. Mother died in 1960 at age 50, and father, described by

the patient as "a rigid and difficult man" died in 1973 from a cerebral vascular accident.

The patient was educated in the public school systems of New York. He described himself as having a small group of friends, participating on the soccer team and being involved in the school's sound system programs and achieving B grades. He went on to Adelphi College as a commuting student which he said he enjoyed. He met his future wife in his sophomore year, graduated in 1952, and married in 1953. He worked for the atomic Energy Commission for one year and then was drafted into the army. In 1956, he returned to the A.E.C. and enrolled in the graduate program at Rutgers University. In 1958, he began his work at Bell Laboratories in Reading, Pennsylvania, rising from physical chemist to project engineer in charge of the measurement laboratories. He published a variety of technical papers and presented twice yearly at scientific meetings. He was in good health during this period, describing himself as a highly-regarded professional by colleagues, a competent loving husband and father of three daughters, spending summer vacations at Myrtle Beach and living the good life until 1974. At that time, six months following his father's death, Mrs. B. reported that her husband became depressed, staring into space in the livingroom. He saw a psychiatrist who treated him with Lithium and antidepressants without much effect. In December 1984, he was admitted to the Reading Hospital, receiving eleven electroshock treatments. He improved considerably, returned to work but was confused and at times disoriented in his location and what he had been doing. In 1977, he was readmitted to the hospital for inappropriate behavior, grandiose thinking, confusion and disorientation. His thoughts were racing, and he spent large amounts of money in shopping malls purchasing dozens of pairs of underwear and shirts. Bell Laboratories terminated his employment in 1978 with a disability pension of $6000 per year. He was hired a year later by Digital Equipment Corporation, moved to Massachusetts and was able to function tentatively for one year before another manic episode hospitalized him. Digital kept him on their books for another year and finally dismissed him. At this time, Mrs. B. began talking about separation and divorce, feeling she could not cope with her husband's ups and downs and periodic bouts of verbal abuse.

My introduction to Dr. B. was in September, 1982. He was referred for vocational assessment. He presented himself as a quiet, rigid, forlorn man of fifty-two years of age and out of work for a year and a half. His inability to attend to issues of work readiness and focusing on alternative career directions using his years of scientific experience was patently evident. His posturing, inarticulate speech and loose thought processes suggested the need for hospitalization evaluation. Within the next week, Dr. B. was an inpatient at McLean Hospital.

I've been following Dr. B. for two years now. His life course has taken a dramatic downward spiral alternating between two inpatient hospitalizations, marginal independent living, separation from his wife and children, barely managing his daily activities, contracting diabetes mellitus, and his attempt to function in a sheltered work program where his attention span and memory cannot negotiate simple two task operations. Today, he receives Social Security Disability Insurance, participates in a psycho-social rehabilitation program and lives alone, by choice, in a near by community. His one-time ambition to return to scientific work has ceased to be an active issue. It has been replaced by the agony of living with a disease that is unpredictable, causing him day-to-day changes in mood and functioning. The initial question at referral

has changed from "what alternative careers are open to Dr. B? to "How can Dr. B. maintain a life for himself outside of a hospital ward?"

Dr. T., a forty-five year old successful dental surgeon was referred to me following his six month hospitalization for a major depression with psychotic features. His admission was precipitated by a suicide attempt of self-inflicted knife wounds to his neck and abdomen. Our first meeting was highlighted by Dr. T.'s determination to "get out of dentistry", his agony of going from his kitchen to the office each day (the office was part of his home) and the on-going frustration of not accomplishing "anything worthwhile" in his practice. He had begun the initial work of putting the practice up for sale and was seeking assistance to change careers. My usual course of assessing vocational potential consists of the administration of the Strong- Campbell Interest Inventory, the Forer Vocational Survey and the General Aptitude Test Battery along with a series of interviews wherein a complete history of personal, education, employment, and medical information are formulated. Dr. T.'s interest scales revealed a high affinity to the human services, medical services and scientific careers. Psychologist, social worker, college professor, minister, optometrist were "very similar" in the Strong-Campbell Inventory. Dentist was low on the "similar" scale. The Forer revealed attitudes of perfection and very high needs for recognition by authority figures in the performance of work responsibilities.

The most revealing data from the evaluation process, however, were found in his personal and educational history. Dr. T. recounted his high school experience with a guidance counselor who suggested a number of options for career directions including teaching and dentistry. He reported this information to his parents and remembers mother clearly deciding that dentistry was the route to follow. Being a dutiful and loving son, he pursued this path in undergraduate school, despite repeating a chemistry course. He was able to enter the University of Pennsylvania School of Dentistry after his junior year at Trinity College and received his D.D.S. in 1963. He was married in his last year of dental school, served in the U.S. Army for two years and returned home with his young family to setup practice in a suburban town not far from his hometown.

He established himself as a leader in the community, serving on the town counsel and school committee. In 1975, he began to acknowledge long-standing feelings of personal inadequacy and unhappiness. His younger son was experiencing major learning problems in school and behavioral problems at home. His response was often tyrannical and heavy-handed, complicating family relations that spilled over into his work life. He sought treatment for his growing depression, receiving both psycho and chemotherapy. At the age of 42, his mother died and Dr. T. became more debilitated. One year later, he made the suicide attempt. As we reviewed his vocational assessments in light of the strong psychological component surrounding his parents influence, particularly mother's perceived power and control on choosing dentistry as a career, "throwing the baby out with the bath water" became our focus. Through a detailed analysis of this work history, especially his military experience, a major theme came to the surface. He recalled his strong positive feelings of working closely with colleagues, sharing cases and collaborating on difficult patients. In addition, his team leader was remembered with fond memories mainly for his choosing Dr. T. as his second in command assisting in teaching rounds and clinical presentations. As we followed this theme into his practice, it became clear that Dr. T.'s very real needs for approval and validation of his work and more importantly, of himself,

were not being fulfilled by his solitary dental practice. Despite an active membership in dental societies, he persisted in feeling a huge void in his "worthiness to his patients."

Over a six month period, the clarification of his personal needs versus his professional skills became more separate and discrete. His psychotherapist and I met frequently to compare notes since both themes were so enmeshed. Dr. T. began the process of considering teaching as an alternative career, speaking to local schools of dentistry and dental hygiene. He also pursued the options of group practice, looking into the "shopping mall" setups.

I'm pleased to report that just this past week, he became associated with a practice in his old hometown with a senior dentist he has befriended over the years and respects a great deal. Naturally, he is anxious but with his new insights into himself, his stronger alliance with his wife and children and his greater zest for living, the future looks bright.

These three cases, I believe present future studies in vocational assessment with many challenges. To return to Botterbusch, if psychological and emotional stability indeed are the most difficult areas to evaluate, perhaps neuropsychological testing should hold a more important place in the assessment process of mental disability cases. Both Dr. A. and Dr. B. suffer from Manic-Depressive Illness. Current research centers almost exclusively on brain functioning, specifically in biologic, electronic and neurologic chemistry. The introduction of Lithium Salts as a major treatment for this disease has been boon for sixty to seventy per cent of it victims. However, Dr. A. and Dr. B. have not been fortunate enough to respond favorable to this state-of-the-art treatment. Their lives currently are a shadow of their former selves. Similar to victims of other chronic diseases, they wait and hope for new discoveries to come forth from the laboratories.

For Dr. T., Botterbusch's emphasis on a complete case history plus the opportunity for extended vocational counseling provided important data for the assessment process to move forward in discovering vital personal information that affected his vocational functioning.

In summary, vocational assessment for victims of major mental illness need to keep pace with contemporary psychiatric research findings. Today, greater numbers of young, professional adults, both male and female are being treated for affective disorders. Through careful review of the six critical areas of vocational functioning and an increased sophistication in the assessment process, hopefully more clients will be able to assume lives of productivity and worth.

REFERENCES

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