help is essential. Women should think of the menopause as taking place normally in one of the following ways :

(1) The periods get less and less, but the interval remains the same.

(2) The loss each time remains the same but the interval between the periods gradually increases.

(3) A combination of (1) and (2). This is perhaps the commonest course of events.

(4) A sudden complete cessation of all menstruation.

Floodings or irregular haemorrhage at the time of the climacteric, although very common, should always be spoken of as an *abnormal change of life*. In the past, practitioners, after correctly diagnosing that the symptoms are due to the menopause, have often reassured their patients by saying it is "only the change of life." When the patient's neighbour suffers from the same symptoms the patient in turn reassures her by saying, "I have had the same trouble, and the doctor said it was only the change," with the result that the neighbour neglects a visit to the doctor, often with fatal results.

Malignant Disease

It is perhaps unnecessary to remind practitioners that the peak of incidence of malignant disease is in the years 45–55, and therefore any irregular bleeding, even if accompanied by hot and cold flushings and other menopausal symptoms, must be investigated completely and immediately to exclude malignancy. It is even dangerous to tell the patient to return in two weeks' time unless a special note is made to remind her if she fails to return. In this connexion Dr. Bishop will, I am sure, forgive me for calling attention to a sentence in his article where he advises that the patient be told to return in two months "after keeping a careful record of her bleeding dates." Dr. Bishop is, of course, referring to patients in whom all possibility of malignant disease has been excluded and in whom it is a question of what type of endocrinal disturbance exists.

Of the various malignant conditions that may cause irregular bleeding, *carcinoma of the cervix* is the most common ; it is often diagnosed by seeing the growth or an ulcer on the cervix. Endocervical carcinomata, which form only a small proportion of these growths, generally show nothing abnormal, but the cervix on palpation is often slightly enlarged and barrel-shaped. The diagnosis can be proved only by biopsy.

Another help to diagnosis consists in taking cervical and vaginal smears, a technique used extensively in America but only to a small extent in this country. Carcinoma of the cervix may occur at any time of life, but is rare before 30.

Carcinoma of the body of the uterus rarely occurs before the age of 40, and is commonest after the menopause. Indeed, there are few other post-menopausal conditions to give rise to irregular bleeding except a rare granulosa-cell tumour of the ovary which also causes this symptom. Carcinoma of the body is often found in a uterus of normal size and can be diagnosed only by a diagnostic curettage.

Carcinomata of the vagina and vulva give rise to blood-stained discharges ; a tumour or ulcer may be seen on examination.

Carcinoma of the Fallopian tubes is a very rare disease which gives rise to a blood-stained discharge, but is seldom diagnosed before operation.

Conclusion

Irregular bleeding is the most important gynaecological symptom of which women complain, but, owing to the fact that very often it is due to a transient endocrinal upset, the patient is likely to ignore it. For the same reason there is an understandable temptation for a busy practitioner to give the patient a prescription for some ergot or other medicine and tell her to return again if the bleeding does not stop. The patient, reassured, may wait for several months, with occasional bouts of bleeding, before once more visiting her doctor, when an advanced growth may be obvious.

It is true that the thorough investigation of a case of irregular bleeding takes a long time, and for an overworked practitioner it is perhaps wise to send the patient at once with a note to the gynaecological department of a hospital. If, however, the practitioner has the time, the following is a summary of the steps to be taken :

(1) A careful menstrual history. If every woman could be persuaded to keep a diary in her bedroom for noting the dates, the difficulty of obtaining an accurate history would be much less.

(2) Decide if the irregular bleeding is or is not connected with pregnancy.

(3) Decide if the condition is purely an irregularity of menstruation or is true irregular bleeding.

(4) Decide if the irregular bleeding is only a symptom of some general disease or is due to a local condition in the pelvis.

(5) If it is a local condition exclude the possibility of malignant disease.

(6) In the case of irregular bleeding never adopt the Asquithian motto of "Wait and see."

Next Refresher Course Article.—"Nephritis," by Dr. Robert Platt.

A SURVEY OF OCCUPATIONAL PROBLEMS IN A NEUROSIS CENTRE

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Roffey Park provides residential treatment for 120 psychiatric cases at a time and maintains close contact with the community as an integral part of resettlement. The stay is about six to eight weeks. The patients undergo comprehensive physical and psychiatric investigation and subsequently a planned régime, including physical training, workshops, and resocializing activities. Appropriate psychotherapy is given in all cases and physical methods of treatment are used when required.

Many patients have become desocialized both in their work and in their communal activities. More and more it is becoming apparent to the psychiatrist that his function is to break the vicious circle of neurosis that isolates an individual from the community and to help him back to his right level and right field in that community. In many instances the neurosis is characterized by a situation in which immature social attitudes lead to loss of emotional rapport with the community. To reverse the spiral of neurotic adjustment, treatment must take into account as many facets of the situation as possible. Hence emphasis is placed at Roffey Park on the communal structure of the centre, the patients' committees, and the various methods of producing a co-operative atmosphere. Harris (1949) referred to these techniques as sociatry, a word that came into common usage during the war but is seldom heard to-day.

An integral part of this reversal is suitable occupational placement. Clearly, many patients have a firm

niche in their organization, to which they return automatically on discharge. This is more likely to occur when the precipitating factors in the maladjustment are endogenous rather than exogenous. In a follow-up in 1949 of patients at Roffey, Ling, Purser, and Rees (1950) found that 81% of those returning to their own jobs in their own firms were making a satisfactory adjustment twelve months later, as opposed to a satisfactory adjustment in only 62% of individuals who had made a change of job.

If a change of work is indicated the problem is usually a more difficult one. It is evident that in the interest of the patient and of the community additional skilled advice must be obtained. The disablement resettlement officers of the Ministry of Labour have an up-to-date knowledge of training facilities and job openings throughout the country. They also have much practical experience of placement, and their views are often very helpful to the psychiatrist at the informal placement conferences.

Many of these difficult cases merit a more thorough study by the occupational psychologist, whose findings are incorporated in the total resettlement programme for each patient. This paper presents our experience in the handling of 50 recent difficult cases.

Brief Description of the Cases

The group presented a diversity of problems in a variety of circumstances. There were 30 men and 20 women, with an age range of 17 to 62 years. About half were between 20 and 29 years, and a third between 30 and 39 years. Fourteen were married, three divorced, three separated, one widowed, and the rest single. In intelligence they ranged from 19 who were at or above the 90th percentile for the general population to nine who were between the 10th and 30th percentiles.

They were classified into three main groups according to the work they had been doing: 18 had been doing work in the mainly practical group, which is largely concerned with making things; 17 had been engaged in work in the mainly office group, the major work emphasis being on problems expressed in words and figures; and the work of 5 belonged to the mainly social group, which largely involves personal contacts. Of the remaining 10, 7 had been so long unemployed that they were disregarded for grouping purposes, 2 were part-time housewives, and 1 was a music student. The occupational range was from a university-qualified chemical engineer to an unskilled labourer.

To give an indication of the work stability of the group a simple index was used. It was the ratio between the number of working years since leaving school and the number of jobs held. This is also, of course, the average number of years spent in each job. The ratio, however, was not so regarded. It was considered simply as an indication of whether the work record was a stable or a changeable one. The range of these indices in the group was from 44 to 1.1. The former referred to a man of 58 who had had one job since leaving school, the latter to a woman of 25 who had had 10 jobs since leaving school at the age of 14; 44% had an index of 2 or less.

The type of case seen at Roffey Park presents a wide variety of symptomatology, maladjustment being the most important item. Nomenclature is notoriously deceptive in psychiatry, and especially in the neuroses, in which personality disorders play such an important part. In terms of clinical disease, a survey of 842 cases in 1949–50 showed 32% depressives, 47% anxiety states, and the remainder mixed states. In the field of personality, 8% of cases were classified as fundamentally good personalities, 38% as average personalities, 45% as inadequate personalities, and 9% as very inadequate personalities. The classification of cases in the present group was approximately in the same ratios.

Approach to the Occupational Problem

It is essential that the patient's problem be viewed as a whole. The occupational aspect can be studied only in relation to the patient's lack of adjustment to the life situation. In general, the neurotic person breaks down because the stresses and strains in adjusting himself to life situations are too great. Consequently, due regard must be paid to the personal, social, and economic factors which are part of the total situation.

In addition, the occupational problem must be regarded as two-sided. On the one hand, there must be a thorough knowledge of the demands made by the work on the people who are to do it successfully. On the other hand, a knowledge of the capacities and personal qualities of the individual is necessary to judge how far he meets the demands of an occupation.

Clearly it is best if the requisite knowledge of both sides of the problem can be built up according to a common plan. The scheme followed in this case is that developed by the National Institute of Industrial Psychology (1951–2). The information about occupations and about the individual is established under seven headings—physical make-up, intelligence, special aptitudes, attainments, interests, qualities of disposition, domestic circumstances—which are occupationally important. With the information thus assembled occupational guidance becomes the matching of an individual to a work situation in which his capacities and personal qualities will be given full scope and from which he will derive satisfaction.

Important Features of the Occupational Problems

In neurosis cases certain features seemed particularly significant, and among many factors the following were especially important.

(1) Intra-personal Factors

These seemed to relate specifically to the individual as a person or as a result of his present condition of health.

(*a*) *Focus of Occupational Interest.*—In many of the cases any such focus was weak or largely unrealistic. It may have been an expression of the fact that the patient had drifted from job to job without any canalizing of his capacities and personal qualities. In some cases it was due to the growing dislike of a work situation without any new focus of interest. Again, it may have been indicative of a feeling of general disinterest. Sometimes the preferences for a job have been incongruous, inconsistent, and incompatible with the other factors of the problem. For example, one patient suggested leaving his job and his house without a reasonable chance of being rehoused in the new work. In such circumstances guidance becomes further complicated. Resettlement depends for success in the first place on the establishment of an appropriate focus of occupational interest understood and agreed by the patient.

(*b*) *Patterns of Interest.*—In many of the cases under consideration these were narrow in scope and superficial in quality. Alternatively, over a period of years they have become narrowed. Interest patterns as an expression of the personality seemed to have two important bearings on the occupational problem. Some of the job preferences were obviously at variance with the individual's life-pattern. Though the relations between patterns of interest and the demands of a job are open to question, their consideration seems of especial value in cases of this type. For example, a woman of 31 who all her working life had been in a minor clerical position expressed a preference for children's nursing and welfare work. Her interest pattern had shown little strength towards the social side and less still towards children. Opportunity of helping in a nursery in the centre

was made available. In a few days it became clear to her that such a job preference was not a sound one.

How far can any occupation supply the satisfaction which is often desired by a neurotic patient? How many occupations can provide such a complete satisfaction? It is questionable whether an occupation should require a person to devote all his capacities and energies to it—that is, to "live for his job." Usually it is more likely that greater satisfaction will be derived from the life situation if an appropriate balance is achieved between the work and the extra-work situation. Consequently it seemed advisable not only to guide some of these patients into a suitable work situation but also to encourage them to achieve a better balance by developing their outside interests. In this way allowance is made for those needs which do not gain satisfaction in work.

(*c*) *Identification and Participation.*—All these cases showed the importance of considering these factors. For example, a young well-qualified chemical engineer felt strongly that the work he was doing was so much below his capacity and so unimportant that he could not make it part of himself. He could not identify himself with the work or feel that he was participating effectively in the organization. He did not "belong." It therefore became important to find the sort of work situation which would help to give him a feeling of identification with the job and a sense of participation in the organization. In this case transfer as assistant to a site engineer on power-station construction has provided him with a situation to which he has become well adjusted. In other cases it may be that a job in a small organization is preferable to one in a large concern. Again, it may be possible for the individual to obtain these feelings of identification and participation as secondary gains through the medium of a firm's social, sporting, and welfare activities. Any changing of the environment which lessens this feeling of separation is a help towards successful resettlement.

(2) Inter-personal Factors

Equally important social factors characterized the study of these 50 cases. They were concerned with the patient's relations with other people. Some problems centred in the patient's capacity to establish satisfying relations with others in the work situation. Others depended on the extent to which the individual could maintain relations for any length of time. For example, one patient seemed likely to be acceptable to quite a wide range of people if the bonds of relationship were short-term ones. In addition, it was thought that she would suit a job where people came to her rather than where she had to go to people. In the light of the total situation this patient was resettled satisfactorily in retail selling.

Another important consideration was how readily a patient could become a true member of a well-integrated working group. Some patients were more suited to working on their own. Others were likely to fit best into a large ill-defined working group where they would derive satisfaction from its very largeness. For example, one patient aged 26, of good intelligence, superficially pleasant of manner, and with quite a strong pattern of social interests, had had a number of positions. Her work situations had involved being either in a well-defined group or in a larger ill-defined group. In every situation the patient's social relations had been very inadequate. It seemed as though she "was always with too many others." She was advised to seek a position where she would be working largely on her own as a receptionist-secretary, and was encouraged to continue her social interests in her spare time. Clearly, inter-personal relationships are important factors in occupational advice.

Factors in Resettlement

In the light of all the evidence it is essential to determine whether the individual is or is not employable. If the patient is employable it is necessary to decide to what extent, at what level, and in what sort of situation he would best function. The advice for the 48 patients regarded as suitable for full-time employment was grouped under four headings:

(1) Cases which involved a radical change of type of work.—For example, a man of good capacity and prognosis who had had a number of semi-skilled jobs and one low-grade clerical position was advised to become a builder's clerk. He would thus be doing mainly office work with a practical background. This recommendation involved a radical change of work which would have to be preceded by a course of training. In many cases a change of work did not necessarily mean a change of firm or any important retraining.

(2) Cases which involved a reorientation of job situation within the firm.—In the case of a tradesman in the maintenance department, where the work was varied, the speed and pressure were variable, and his inter-personal relations were inadequate, a change of work and of department seemed desirable. A department was indicated where the work was more regular and the speed more moderate, and where he would have a chance to establish better relations. Placement of this type necessarily requires close co-operation between the centre and the personnel departments in industry.

(3) Cases which involved a reorientation of job situation but with a change of firm.

(4) Cases in which continuance in the present job with the same firm was indicated. In some instances this solution was not ideal. In fact, it was thought that as any change would involve the patient in new and different situations it was better to make no change.

Of the 50 cases a radical change of work was indicated in 23, a reorientation of job within the firm in 5, a reorientation of job but with change of firm in 9, and by continuance in present employment in the same firm in 11.

It is evident that training or retraining may be necessary in final resettlement. A Government training course seemed desirable in nine cases. Three others were able to do a full-time training course privately, and six were advised to take up or continue with part-time or evening training.

To ensure that resettlement is effectively achieved, staff co-operation is essential. The doctor, psychologist, social worker, and disablement resettlement officer all have their part to play. As in a quartet, the result is effective only when they are attuned to one another and working as a team. No less important is the degree of co-operation displayed by the patient in his own efforts to achieve resettlement.

Co-operation in a wider field is also necessary. Suitable contacts with the community are equally important, as they are in general hospitals. In resettlement the industrial medical officer and personnel manager have an important part to play. Success is often dependent on the extent of two-way communications between the hospital and industry, and the occupational psychologist has an important role in interpreting one community to the other.

Summary

A survey of 50 of the more difficult occupational cases in a neurosis centre is presented in which the medical staff and occupational psychologist have co-operated closely. A characteristic feature of the group was the marked uncertainty over their future work.

A review is made of the type and diversity of the cases and of the methods of approach. Certain personal factors and group relationships are important in occupational problems of this type.

Emphasis is placed on the value of a team approach by doctor, psychologist, social worker, and disablement resettlement officer, and in good communications between hospital, industry, and the community.

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