

## Rehabilitative Psychiatry

(1996)

In general, clinical services, like psychiatric medication, hospitalizations and therapy, have been separated from rehabilitative services, like supported housing, job training, self-help groups and clubhouses, with the rationale left from state hospital days that once the illness had been adequately treated and stabilized, then lives could be rebuilt. This approach inevitably led to two tragic outcomes: (1) The system becomes incredibly fragmented and very difficult to use effectively, and (2) numerous people are attempting to live in our communities as patients waiting and hoping for years and decades to be stabilized enough to begin rebuilding their lives.

At the Village, from the very beginning, the emphasis was placed on integrating services and rebuilding lives regardless of how ill a person is. We are not providing clinical care for mental illnesses with some rehabilitation attached for people who were "ready," "motivated," or "appropriate." We are a psychosocial rehabilitation (PSR) program that integrates clinical care within it. As our first psychiatrist, my challenge was to find a way to use my skills and treatments within the PSR framework.

The first step in this integration was to change my focus from treating illnesses to helping people. At first glance this may seem a semantic, "politically correct," differentiation, but in practice it can be very different. Two extreme examples to illustrate: The treatment of shock therapy can be very effective for the illness of psychotic depression. It can within a couple of weeks drastically improve a mute, starving, catatonic, suicidal person with only modest side effects and very limited need for the person's motivation or help. It is, however, usually a very bad experience for people. They can feel very traumatized, stigmatized, out of control, hopelessly damaged, frightened by the memory loss, fearful of relapse and can suffer ongoing nightmares and blame it for everything that happens to them after that, losing all sense of self control and self determination.

On the other hand, street outreach, where we talk to a person who has schizophrenia regularly and bring him a lunch, and a blanket and a Christmas present, etc., can be a very good experience for a person. It can break into their invisibility and isolation, help them begin the long slow road back to belonging to society, and help them build trust so they can accept other assistance like money, housing, showers, clothes, medication, substance abuse treatment and employment. However, a sandwich twice a week is a very bad biological treatment for the neurochemical illness of schizophrenia.

To be a part of our PSR community I had to help people instead of treating illnesses. Their medications and other "treatments" had to be in service of their quality of life goals, and not just to stabilize symptoms or avoid hospitalizations.

In medical school, I was taught a clinical model for approaching my work. Someone would come to me as a doctor with a problem, a weakness. We would make an unspoken agreement that they would allow me to poke and prod them, they would tell me things they wouldn't tell their best friends, and in general submit to my will, and I would agree to use my strengths to cure them. I would make a medical diagnosis, which I might or might not share with them, depending on if I thought they could handle it, and prescribe some treatment, usually including medication. They would consent to comply with my treatment and sign something saying they wouldn't sue me if something went wrong. When they returned (although in fact 1/3 of public mental health patients don't come back after their first appointment) I would assess the symptoms of their illness, any untoward side effects, and the patient's compliance. This process would continue until I had cured or at least stabilized their illness. Unfortunately for many serious mental illnesses this can be a very elusive and often unsatisfying end point and the relationship can easily degenerate into "treatment resistance."

At the Village, I developed an entirely different, PSR model of medication collaboration. Now a person comes to me with a goal of something they want to accomplish or change about their life. Through the process of planning together this change, we may discover things that I can do to be helpful. It may be that some of the knowledge I have about neurochemical illnesses, emotional conditions, interpersonal relationships, family or social systems, or even about piano playing or the Lakers, may help clarify the planning process. It may be that I'm aware of some treatments, usually including medication, which may assist them in reaching their goals. I'll consent to help them with their goals and educate them about and offer them choices. They may choose to include in their plan something I've offered if they think it'll help them achieve their goals. Since there are many overlapping and redundant medications available in psychiatry, they can usually have several to choose from. When they return (and virtually all do, because a man of my training and talents can usually find something helpful I can do, even if it's just writing a letter or filling out a bus pass form), we will discuss how they're doing on their goals and if my help can be improved, not how their illness (that they may or may not think they have) is being treated. There is very little reason for "noncompliance" because they made up the plan and the goals, not me.

For example, a man came to me asking for help because he was hearing voices. I didn't inquire into causes of voices. I inquired into what would be different about the quality of his life if he didn't hear voices; what goals the voices were interfering with. He told me he wanted to date women, but whenever he tried to talk to a woman the voices said he was stupid, fat, ugly and that it was hopeless, and he'd get so demoralized he wouldn't even try. I used some of my knowledge about psychosis and antipsychotic medication to offer him a list of 10 choices of medications all with various possible advantages and disadvantages. He chose Haldol 5 mg. at bedtime. When he returned, I didn't ask how the voices were. I asked if he'd talked to any women, since that was his goal. He said no because although the voices were much quieter now his hands were shaking so terribly he was embarrassed. I hadn't helped him as a person even though I'd treated his illness. We reviewed various choices of medication changes and kept working towards the goal of dating women.

With this approach to medication collaboration, I had made substantial progress to becoming integrating into a PSR community, but there were substantial problems. Some people didn't seem to want to use medication to improve their lives. They wanted to achieve pleasant, altered mental states chemically without doing anything to change their lives. Clearly street drugs and alcohol are much better suited to this purpose than psychiatric medications, and most people like this know that and do use them. Sometimes they want to add psychiatric medications too. These people also tend to take pills in a very different way than they were intended to be used and can get into dangerous situations as a result. I was taught to refuse to prescribe any medications for these people (unless, of course they're in an emergency room or hospital where we can control them and avoid substance abuse). I have instead searched hard for common ground to collaborate on. Sometimes these people have other goals, like avoiding violent behavior, or avoiding hospitalizations, or thinking more clearly so they can function, that we can agree on and I can help with. Sometimes we have to use a controlled medication delivery system, like picking up the pills daily at the Village or getting decanoate injections every 2 weeks to preserve safety. Sometimes we have to avoid certain medications, like Lithium, that are most likely to be dangerous. I also keep in mind their substance abuse illness which ultimately will kill them if they don't recover. I avoid addictive medications to avoid worsening their illness and I emphasize antipsychotics to promote clearer thinking to make it more likely they will pursue recovery. I also use medications symptomatically with a recovery program to try to help them be able to continue in the program. After a lot of work, most of the time I can be somewhat helpful.

Another group of people that are problematic are people whose view of their lives is so different from mine that I strongly disagree with their decisions and can find very little common ground. I was taught to force these people to take medication, whenever the law permitted me to. I have instead searched hard for an understanding of their perceptions of their lives. For example, I let them not take medication while I continue our relationship, and try to be helpful in other ways. A man with schizophrenia came into my office late one afternoon, held up his hand palm facing me and asked me, "What do you see?" I said tiredly, "Your hand." He said, "No, no. Be more specific. What do you see?" I said, "OK, I see the swirls of your fingerprints, the creases where your fingers bend and those lines that are your love line and life line. I don't know which are which, but I can see them." He said, "When you can see nails, and knuckles and hair then you'll be able to help me, because you'll be seeing the world from my side, instead of from yours." It is our obligation as mental health professionals to understand their worlds to figure out how we can be helpful. It's not their obligation to understand DSM IV, and our clinic structures and our rules to figure out how to get help from us. Somehow we've become so fearful that we'll increase their psychosis by "playing into it," that we cut ourselves off from connecting to some of the most dramatic and influential experiences people have. I've helpfully entered many unusual worlds: I've helped strengthen minds so demons couldn't get in. I've had pills blessed by a minister. I've helped to build a mental block to keep the neighbors from using ESP to put thoughts in someone's head. I've helped ease the pressure someone felt from a conspiracy trying to force him to kill himself, and so on. Often I can find ways to be helpful even when someone's not "competent" enough to agree with my view of the world.

A woman once told me that she used to become very psychotic and violent and the police would tie her up and take her to the hospital. The people in the hospital were all very nice and they took care of everything. They made sure her belongings were safe. They fed her and bathed her and clothed her and gave her medication. And it worked. Within a week or two she was feeling much better, thanked them and went back home and returned to her life as it was before. Within a couple months she became again very psychotic and violent and was dragged into the hospital. After a while they started blaming her for being a "revolving-door patient." She thought that the problem was that she had never been included in the process of recovery. She didn't know why she was suffering, how it connected to the rest of her life, what its meaning was, and what changes she'd have to make to recover from it. Many people have to make substantial changes in their lives to recover. Forcing them to get short term symptom relief may not be nearly as important as engaging them in a process of self understanding and

change. That engagement is almost always better begun by entering their world than by forcing treatment, although admittedly at times dangerousness forces me to try to do both at once. The goal is helping people, not treating illnesses.

A third group of people that are problematic are those that have give up being people altogether and have become chronic mental patients. They become adoring, dependent patients willing to follow (or at least agree with) any orders I make. They regularly go to the hospital to avoid responsibility and to be taken care of. There's often, however, an empty, depressing underside to their lives. They have no real goals, or hope. Their lives revolve around cigarettes and coffee, and the main thing they look forward to when they get up in the morning is being able to go to sleep that night. It can be very difficult to find the person that's seemingly been swallowed up by the illness to collaborate with, to empower, to help recover.

When I was at the Meninger Institute, a fancy, expensive psychoanalytic hospital on a very large, snowy campus, one winter as a medical student, I met a twenty year old man with severe catatonia. He would talk to me if I approached him, but if no one did he'd spend hours perfectly still in his slumped catatonic pose. The staff and patients went for daily walks in a group together. On this occasion the psychiatrist, dressed in an expensive suit and tie and wearing slick patent leather shoes, began to slip and fall. The young man began to help him, guiding him by the slick spots and helping to hold him up. When we returned to the ward, the psychiatrist straightened up his clothes and returned to his role as psychiatrist and the young man resumed his slumped catatonic pose and returned to his role as patient. If we want the people we're trying to help to become something besides chronic dependent mentally ill patients, we have to act like something besides chronic caretaking mental health professionals.

I've found two approaches to be helpful in this regard. One is a standard PSR technique of finding positive things away from the person's illness to relate to, preferably shared interests. I was giving a presentation about medications one afternoon on a panel with two people with chronic schizophrenia that I had never met before. They were both rather slowed and dulled with very little to say who were satisfied with seeing their psychiatrists fifteen minutes, once a month because they had nothing to say. The presentation was dying, so I began asking them about the rest of their lives besides medications. It turned out the woman was in a bowling league and baked for the local Sunday school class and knew a lot about buses in Hollywood, and the man used to volunteer in the basement of the Hall of Records where the archival photographs of early Los Angeles were kept. As they talked about these things they both literally came

to life before our very eyes. (Their "negative symptoms" evaporated.) When I couldn't get them to stop talking, I interrupted and asked why they said they had nothing to say to their psychiatrists when they had so much to say to me. They replied that their psychiatrists never asked about things like this, they just asked about their voices and paranoia and sleeping habits.

The second approach I use is to reveal one of my numerous human flaws, to take me off the physician pedestal and by doing so bring them up. One morning I walked into the Village rather upset and one of the members who'd had social skills training said "Hi, good morning, how are you?". I said, "Not very good." He stopped and looked at me puzzled because I had missed my expected line in the dialogue of "Fine, and how are you?" and, after a pause, asked again, "Hi, good morning, how are you?" I said, "Really not very good. I've just had a big argument with my wife and I'm pretty upset." This freaked him out entirely and he ran off leaving me feeling even worse than I had been before. The next day, however, he returned and said, "I'd like to apologize." "Apologize," I said surprised, "for what?" And he said, "I realized yesterday that you have problems too. They may not be as big as mine because you don't have a mental illness and you have plenty of money and a home and a family, but yesterday you were upset and I wasn't there for you. I just walked off. And I'm sorry." Our relationship has never been quite the same since then.

We've been carefully taught, firstly as part of learning professionalism, and secondly as part of learning to avoid countertransference contamination, not to find shared interests or self disclose flaws; in effect not to share any of our real selves. This has served primarily to cut us and the people we work with, off from our most healing parts. Presumably we were reasonably caring people who wanted to help people when we decided to go into this field. Presumably we're able to be helpful and healing to our friends and family without the armor of professionalism or psychoanalysis. Why do we have to hide ourselves when we work with people with serious mental illnesses? How can we expect to empower the people we work with to trust themselves and their feelings and to explore their human potentials, when we've been trained to do the exact opposite ourselves? (Be careful of this line of questioning, you'll find yourself wondering about a number of sacred practices).

A psychiatrist from Taiwan, who was visiting the Village and watching me work, said that he had just come from Fountain House in New York, the most venerable of clubhouse programs, and that they'd told him that a psychiatrist couldn't be included in a PSR clubhouse model for two (2) reasons. Firstly, when someone sees a doctor, for

treatment they become a patient instead of a person and they did not want their members to become patients in their clubhouse. Secondly, in a PSR clubhouse everyone has to be a generalist, and psychiatrists are specialists in treating illnesses. It seemed to him, however, after watching me that I was helping people without turning them into patients and that I was a generalist and active in many areas of their lives and in many roles. I think both of these points are crucial and both must be overcome, as I've worked to do, to be included in a PSR community and to create integrated services.

I believe it is possible, in fact preferable, to treat serious mental illnesses without making people into patients. Every time I go to the doctor's office, and tell them I'm a doctor, they help me without making me a patient. I'm treated as a colleague even if I've never met the doctor before. I'm trusted and respected and included as a valued collaborator in my own treatment. This is very different from how I'm treated when I don't say I'm a doctor and I'm turned into a patient, but my illness gets treated either way. Why can't we treat everyone the way I'm treated when I say I'm a doctor? Technically, I think it is possible to assess a person as part of a PSR planning process and socially getting to know them, without resorting to a structured clinical interrogation. I think it is possible to assess psychopathology and behavior while playing pool in a clubhouse, without resorting to a clinical checklist. I think it is possible to give medication advice over lunch without making an appointment for a medication check.

A man I work with who was severely traumatized by the Khmer Rouge as a child recently returned from his first trip back to visit his family in Cambodia. His case manager thought he looked stressed when he returned, but he wouldn't respond to any of her questioning and she asked me to assess him. I was showing pictures from my vacation to Alaska to a group of members and staff sitting around my desk and urged him to go home and bring his pictures from Cambodia to share with us too. He did, and we talked about visiting the ruins at Angkor Wat that I would like to see, the native healers his family took him to and his reactions to seeing his parents' graves. By the time we finished, I had completed a good "clinical assessment" as well as learning a number of fascinating things and having a good time. He left saying maybe we'd go together if he returned to Cambodia in six years, feeling like a friend instead of a patient.

I am often told that this all sounds wonderful but it is impractical. Psychiatrists are so expensive that they cannot be paid to play pool and show trip photos. They must be restricted to fifteen minute medication visits once a month in a highly structured, highly

scheduled environment to save money. Rehabilitation and recovery have to be done by someone with a lower salary and the psychiatrist kept as a specialist in treating illnesses. Not only does this result in wasteful fragmentation and seriously undermines their rehabilitation and recovery, its not even very good clinical treatment. In order to get accurate detailed information to truly diagnose someone and in order to gain understanding and collaboration from the person to seriously contribute to their own recovery, a much stronger relationship is needed than is possible in the specialist model. After the first six months of the Village, I had changed the diagnosis of one third of the members (primarily schizophrenia was overdiagnosed), changed the class of medication for one third of members and raised the dosage for one third, lowered it for one third and stopped medication entirely for one tenth. As a result two thirds had less symptoms and seventy percent had less side effects. At that point, half of the members who had a substantial rehabilitation improvement had it preceded by a substantial medication improvement. Hospital utilization and non-compliance dropped dramatically. Over all very few members had been getting the best treatment possible for their illness in a fragmented specialist model. We expected them to contribute heavily to their own recoveries, and they have. Six years later three fourths of our original members are still with us. An outside evaluator in year 3 rated almost 90% as no longer having any observable symptoms of their mental illness during their interviews. My conclusion is that the fragmental specialist model not only is not as good for rehabilitation, it is not as good for clinical care either. How efficient can that really be?

I think that what is important in being a generalist is to relate as a whole person sharing a life with another whole person, rather than as a strong specialist helping a weak patient, and to relate in as many different roles as possible. I am the "Village doctor", but I am also a great many other things in our community, a husband and father, a sports fan, a mediocre piano player and good chess player, a customer at the cafe and mini-mart, a lecturer and writer, and a sloppy dresser. I walk around like in an old Jimmy Stewart movie giving out some pills and advice, asking about the job and wife and kids, sharing gossip and going to funerals, making house calls and commiserating about life's ills. Overall I think I've become successfully integrated as a valued member of our PSR community and I have enjoyed doing it.

Over the past several years I have, along with a member of other people in the PSR field, been drawn towards a recovery vision. This vision, as I have experienced it, and as it has been articulated by people in recovery, is a much closer cousin to the 12-step view of recovery than to the medical view. As a doctor, I am generally incapable of

imposing a cure on people with serious mental illnesses. (Actually doctors of all kinds are close to incapable of curing any illnesses that come from within us, regardless of what part of the body they affect.) I have experienced people recovering, however, and many would describe themselves that way. They have recovered things in their lives, like houses, jobs and relationships. They have recovered functions in their lives like concentrating, working, and loving. They have recovered internal mental states like self esteem, peace of mind, and a sense of identity. In many cases they have "recovered" in ways they never experienced before their illnesses. This has been to a great extent an internal process of change and growth for them, although, I think I can promote it through empowerment, caring and empathy. When someone is recovering, a great many things, like medications, therapy, training, and opportunities to help others, can be tools in that recovery. When they are not recovering, almost everything seems to go for naught. I do not know if this is a spiritual process as 12-step programs and many people with mental illnesses believe, although I do know I'm touched at times when I'm sharing it with someone. I also know that it rang true when I heard another doctor say that what ruins medical students is when they replace a sense of mystery with a sense of mastery. Undoubtedly, many people working with a clinical approach have promoted recoveries, but that model contains very little to explain what's happened and very little comfortable common ground for the "recovery movement" to integrate with. On the other hand, I've found that my "rehabilitation" approach to psychiatry appears to translate very easily into a "recovery" approach. I have enjoyed the added satisfaction the recovery vision has brought to me.

In closing, although I have seen very few of my fellow psychiatrists working in a rehabilitation-recovery model like I have described here, I believe that the vast majority could if they were working as valued, empowered members of a PSR community as I have been. I think many would find themselves rediscovering why they went into this field in the first place and reconnecting with healing powers within them that had been professionalized, psychoanalyzed, specialized, regulated, "risk-managed," cost controlled, and unappreciated into submission.