To be fair, if psychiatrists want to be integrated into the public mental health system instead of marginalized, we'll have to extend ourselves as well. We can expect to be paid well and even respected for our ability to prescribe medications effectively, for our willingness to take medical and legal responsibility for our patients, and for our willingness to treat far larger numbers of patients than we can really get to know or keep in our heads and hearts, but we can't expect to be included in the ways I've listed above if that's all we can contribute. Many psychiatrists at present seem to feel those things are enough. So do many training programs. It isn't.

During the Village's first years we had a few psychiatric residents come to do elective training with us, but it wasn't until 1995 when we established an ongoing relationship with UC Irvine that we really became involved with training residents. They came with basic diagnostic and medication skills, so we focused on developing them as psychosocial rehabilitation doctors. Our training was mostly through modeling and immersing them in our recovery based culture. It was a substantial culture shock for them, but almost all of them adapted within about six months and then began to grow substantially. For several of them it was a life changing experience as they were able to go beneath their new professional trappings to reconnect to why their hearts had gotten them into this field in the first place and find the doctor within them.

Training Psychosocial Rehabilitation Psychiatrists

(1997)

Psychiatrists who are working with people with persistent serious mental illnesses often want to include rehabilitation as part of their patients' treatments. Most commonly the framework is that first the psychiatrist and/or therapist will clinically treat the patient to stabilize their illness and their symptoms and then they will be ready for rehabilitation. Numerous pitfalls exist with this approach including prolonged searches for "readiness", chronic "patienthood" and dependency, decreased self confidence and willingness to take risks to grow, over interpretations of "normal" life as symptoms, settling for disability and its "benefits", ongoing resentments, frustrations and anger, "noncompliance", "survivors" not of illnesses but of the treatment system itself, etc, etc.

I have developed and promoted an alternative approach where the psychiatrist is fully integrated into the rehabilitation program and recovery community along with the person we're working with. I use my skills not as preparation for rehabilitation and recovery, but as tools to promote rehabilitation and recovery.

I've become one of the very few psychiatrists who is an active member of rehabilitation agency associations. When I describe my role to these agencies, they're always interested, but say that their psychiatrists are nothing like me. Their psychiatrists are entirely symptom focused. They treat people as patients. They're not part of the team, etc. Frequently, they even have groups and role playing for their clients about how to talk with their psychiatrists as though psychiatrists are another insensitive one of "them", the outside system. A new case manager at our program complemented me saying she was surprised at how well I talked with a new lady, opening her up, making plans, treating her respectfully

since she's always experienced psychiatrists as bad, distant, and insensitive. How can we get back on track?

I've found that for me to be an effective part of a rehabilitation/recovery program, I've had to change many traditional ways of working that I had. I've also found that little in my previous work or training had given me any substantial direction as to how to work in a rehabilitation/recovery setting. It was entirely missing from my residency education. I have tried to contribute to teaching psychiatry residents about rehabilitation and recovery in a variety of ways and I'd like to share some of my thoughts and experiences.

I've begun viewing teaching rehabilitation and recovery as a process analogous to teaching psychotherapy (I realize that this too is a dying, neglected part of psychiatrists' training today, but I'm just old enough to have been taught to be a psychotherapist and to know it's different from, although compatible with and actually synergistic with being a doctor). The psychosocial rehabilitation model has distinct characteristics of the kind of helping relationship that is desired, theories about paths to recovery, techniques to promote it, and visions of the desired outcomes. (Once again, they're different from, but compatible and even synergistic with medical training).

The kind of helping relationship in the psychosocial rehabilitation model is really quite different from the traditional doctor-patient relationship and probably the most difficult change for residents to make. The relationship is not centered on a powerful helping professional taking care of, protecting, and helping a weak, vulnerable, damaged patient. It is centered on helping someone with a mental illness define and pursue their own goals and life visions, empowering and educating them to learn to overcome their own illnesses, and encouraging risk taking and growth, learning from natural consequences and failures. It is far more like the role of coach than of doctor. Most of us naturally make this change when we are trying to help a friend or another doctor, treating them as colleagues or collaborators rather than as patients. However, we have been carefully trained not to make this same change with patients in our daily work. That would be "unprofessional." To make matters even more difficult, most people with serious mental illness often seem so different from ourselves that it's very hard for us to view them as potential colleagues or friends.

There are also frequently other reasons for not departing from the medical model doctor role. One resident told me she wasn't yet comfortable enough being a doctor to give it up and besides she just wasn't comfortable eating lunch with a mentally ill patient. Another one from a foreign country said he didn't think he could get respect from American people without a strong doctor role. Another one was the 12th male doctor in his family and had been groomed his whole life to be one.

On the other hand, a medical model role is simply unsuited to building a rehabilitation relationship with many people with serious mental illnesses. Before we seek to further imitate our medical colleagues we should remember how much difficulty they usually have forming working relationships with people with serious mental illnesses. Becoming a "doctor of the brain" by learning how to treat neurochemical imbalances is in no way sufficient to meet the daily challenges of our work. Once residents do make the change to a collaborate role, which seems to take about 6 months, they describe feeling liberated, more

in touch with the reasons they became a psychiatrist, closer to the people they work with, and more effective.

The second difficult adjustment is that unlike the medical model where the effective treatment modality is the doctor-patient (or therapist-client) dyad, in a psychosocial rehabilitation program the effective treatment modality is the recovery community itself. The staff, other patients, volunteers, and even other neighborhood participants are all part of everyone's recovery. This is somewhat analogous to the old psychotherapeutic milieu. The psychiatrist is just one member of the community, although potentially a very important one, and our contact with the member needs to be coordinated with the rest of the team and even the entire program's community to be effective. As one resident recently put it, he's been on teams before where several staff each work with the same patient, but never where they actually worked together as they do at the Village. We're far closer to interchangeable generalists than a multidisciplinary team of specialists. Once psychiatrists leave hospital and university settings, it is rare to find hierarchical medical model teams where the psychiatrist gives orders. Residents should be trained in other team models and milieus.

The actual techniques of rehabilitation also require a paradigm shift to use. The process is not one of treating illnesses, while someone else handles the rest of what's needed. It's one of helping people in their entirety. That's what a good doctor used to do. One resident said that at the Village instead of learning how to refer patients to a social worker, he learned how to be a good doctor. The focus is not on relieving symptoms or suffering, but on promoting personal growth and change. Teaching someone how to use medications to help gain control of their illnesses is often more important than the actual symptom relief. Helping someone find their lost child, getting them SSI, or persuading them to go to a substance abuse program are often more important than assessing their illness.

Once that paradigm shift is made the actual techniques are not that difficult to learn. The essential techniques of psychosocial rehabilitation include: 1) helping someone form a vision of their own recovery, 2) training in goal setting and accomplishment, 3) forming emotional connections with people with severe mental illnesses, 4) treating people with respect, 5) empowering people, 6) giving hope, 7) teaching self- management of illnesses, 8) various in-vivo skills training and modeling, 9) social network building, and 10) community integration. These techniques are generally not taught in psychiatric residency programs. Nonetheless, they are very helpful to the people we work with.

The outcomes of our work are another important focus. Most residents are very discouraged in their work with people with serious mental illnesses. They've predominately been exposed to either revolving-door hospital patients or medication maintenance clinics aimed at prolonged stabilization. One is frustrating and the other stagnating. In a rehabilitation setting, residents can share people's recoveries first hand. Dramatic quality of life improvements occur regularly building hopefulness and job satisfaction. Residents who work in community settings as part of their residency repeatedly choose careers working in those settings. Careful, long term, longitudinal studies of outcomes of schizophrenia repeatedly are more hopeful than we are. This is especially true when quality of life outcomes are used instead of strictly clinical outcomes. We want residents to evaluate their work on if people have improved quality of life, increased community integration, increased self management of illness, and

increased productivity and role performance, not just if they're symptom free. Once again, we're trying to help people, not just treat illnesses.

In conclusion, I have tried to present and teach a comprehensive view of psychosocial rehabilitation. I see it not as an adjunct to clinical treatment, but as an integrating model. It includes a clear vision of the therapeutic relationship, techniques, and desired outcomes in a far more relevant and meaningful way than a strictly medical model for people with serious mental illnesses. As such it deserves to be included as an important part of psychiatric residents' training.