A review of some personal practice changes individual psychiatrists can make to be more recovery- based

Psychiatrists Can Make Personal Recovery-Based Changes

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The recovery movement has brought us an array of new approaches and treatment relationships, but implementation and change has been slow. Our systems, our program cultures, and our personal practices are still firmly based in traditional practice models and incentives. While an integrated, comprehensive approach to change will ultimately be needed to truly transform services; there are a number of things that psychiatrists can do individually to change our own practices. Focusing on personal changes puts pressure on us to change things under our control instead of waiting to do something differently if only it were possible.

We can't change things just by adding more to our practice. We have to "put down" some current practices to make room to "pick up" something new. This paper briefly describes seven such "putting down to pick up" changes.

1) **Moving from diagnosis centered to person centered treatment**

I was taught that the foundation of medical treatment is to diagnose an illness and then prescribe treatment based upon that diagnosis. To practice rationally and effectively, to be "real doctors", required diagnosis based treatments even for psychiatrists. There was always, however, some caution expressed about this approach: We aren't treating "the gallbladder in room 6". We're treating Mrs. Smith with a gallbladder illness in room 6, or Mrs. Jones, or even Mrs. Wu. But practically, they all got the same treatment because we were, in fact, treating diseased gallbladders, not people. Even if Mrs. Wu had a radically different diet than Mrs. Smith and Mrs. Jones we did the same things.

Over the years of my career, psychiatric diagnoses have become broader and broader and lumped together. Today's "bipolar disorder" includes millions of people of all ages including people I would describe as having rape trauma, amphetamine effects, borderline personality disorder, emotionally immature teenagers, developmental trauma disorder, responding to chaotic lives and relationships, along with more traditional manic depression. The "diagnosis" of bipolar disorder only seems to be related to medication selection and obscures all other treatment choices.

Even if we make a concerted effort to discriminate between more specific diagnoses, we'd still be wearing blinders limiting our treatment choices. So much of how an illness impacts a life depends upon how that individual person responds to that illness. The range is enormous from people who don't believe they have an illness at all and refuse all medications and therefore can only be engaged with other, non-medically defined services to people who become very passive, helpless, and irresponsible because "my bipolar made me do it". Effective treatment choices need to be based upon the individual, not just their diagnosis.

Once we begin to consider person – centered treatments instead of just illness-centered treatments we open ourselves up to learning a whole new array of treatments. Some of my most common new tools include: Motivational interviewing, linking treatment to their goals, trauma informed services, exploring personal meanings of illnesses and medications and self stigma, and building trust by convincing them that "you're not just a case to me".

I now focus on "non-specific treatment factors" which probably account for about 2/3 to ¾ of the effectiveness of any treatment - things like a collaborative trusting relationship, a shared understanding of what's wrong, a sense of being cared about, a shared plan to go forwards, a feeling of hope not just reassurance, etc. "Non-specific" factors aren't really "non-specific"; I just specified a list of half a dozen crucial factors. What they really are is "non illness specific factors". They're "person specific factors".

I've met a large number of people who had "treatable conditions" if only they had been "treatable patients". When I started focusing on treating people instead of their conditions I became much more effective.

2) Undoing the "God course" and "do no harm" to share responsibility

Anyone who has succeeded in becoming a doctor has beaten the odds. Something like ¼ of all kids say they want to be doctors when they grow up and we're the ones who made it. At every level we outcompeted those around us. We won the prize of medical school, so we were "deservedly" proud of ourselves and arrogant when we arrived at medical school.

We were mentored by people who had continued in this competition and succeeded to become medical school professors. They were even prouder and more arrogant than we were and regularly "put us in our place". They taught us the "God course". It began with motivating us to memorize book after book by warning us that "if you don't learn this someone could die later on." This wasn't meant to be preparation for humility, powerlessness, shame and guilt when someone died. Quite the contrary; it was meant seriously. We were expected to learn everything and then no one would die unnecessarily. Our graduation certified this accomplishment by making us swear we'd "do no harm". Only God can do that, and I even wonder about him. Strangely enough, our patients buy into this Godlike expectation we'll never harm anyone. Our society buys into it. Malpractice lawyers and juries buy into it too. Human mistakes aren't acceptable (This belief persists despite the enormous morbidity and mortality form "medical errors".) Because of the complexity of every situation and relationship I'm likely to inadvertently do harm to everyone I try to help. The ones I'm most involved with I'm most likely to harm…and help.

It's a lot of pressure to be Godlike every day (and to do it rapidly) and to take responsibility for always being right and fixing everyone, but doctors have been selected for and trained to do accept this unrealistic burden. In response to these expectations and pressures we've created a system where doctors rapidly give orders, that people consent to but don't really question and then they comply with our orders. Or they don't comply, in which case the treatment failure is their fault, not ours. As doctors are being called upon to treat more and more conditions that are the results of unhealthy behavior and

require behavioral changes to return to health, this model is falling apart more and more. In psychiatry we've been facing widespread "noncompliance" for years and developed biologic, illness based explanations for noncompliance and coercive medications.

Moving away from authoritatively taking responsibility for people's health and lives opens the door to, more actively promoting patient responsibility. I've worked on developing skills in empowerment, goal setting, collaborative meds, shared decision making, shared responsibility and not feeling like I can control their decisions and lives, pushing self help, and learning together with people.

3) Moving from dependence on meds to self responsible use of meds

Psychiatric care has a number of difficult and high risk situations – trying to connect with people "out of touch with reality", calming very distressed people down and decreasing dangerousness, assuring people meet social responsibilities (like driving a car, owning a gun, working, legal competency, and raising children) . We've learned how to use medications to assist in all of these situations, coercively if needed and other techniques have withered. Our growing dependence on medications has given them powerful emotional impacts – "you're upset because you're off your meds." "I can't talk to you when you're like this." "Please get them back on medications. I can't handle them like this." "You have to stay on your meds forever if you're going to live a normal life." "You need to be stabilized on your meds to be ready or to be trusted". At this point we trust medications more than we trust the people we serve…or ourselves.

We increasingly rely on medications to protect us from risk. Once again, our society and our lawyers have bought into this naïve notion. We're afraid of being sued if we help someone get off medications or try to treat them without medications. What if something bad happens?

We're emotionally dependent on medications and our addiction is growing.

If we can turn away from medications, we can open up a whole world of interpersonal and self-help techniques – "talking them down", sharing suffering to help work through it, CBT for a variety of conditions including psychosis, self soothing skills, recognizing signs of relapse and risk factors, WRAP plans, etc. Then we can turn back to medications, not as something people take, but as something they use. Medications become a self help tool instead of a tool for external control. There are a variety of patterns of using medications helpfully besides "take them for the rest of your life and shut up."

4) Moving from compassion to empathy

Most of us truly care about the people we serve. Our compassionate feelings, when "our heart goes out to them" usually including sympathy drives us to wanting to help them. Sometimes we're distressed when we can't help them and they continue to suffer. We may experience "compassion fatigue." This may lead to trying to separate ourselves from our emotional reactions to the people we serve and their suffering. We may create boundaries and professional distance. We'll likely be perceived as less caring while paradoxically we're trying to protect ourselves form caring too much.

Compassion can be defined as our emotional reaction, and urge to help, in response to someone else's suffering. In contrast, empathy is a vicarious experience of the other person's emotions. We likely have to quiet our own emotional reactions to pick up on their emotions. "Relating to what they're going through" usually increases compassion, but it may be an obstacle to empathy.

While compassion may leave us feeling drained, empathy usually leaves us feeling connected, calmer, and more whole. I doubt there is any such thing as "empathy burnout."

Empathy is seeing the world through their eyes. While we may see a "manipulative, dually diagnosed, non-compliant person" or more sympathetically "a trauma victim with labile moods", they may see themselves as a "misunderstood prophet of God." Empathy is an important foundation for "meeting people where they're at," shared decision making and client-driven goal setting and treatment planning.

Empathy also opens the door to Carl Rogers' healing triad. Briefly, Carl Rogers proposed that healing isn't something we do to someone else; healing occurs when we stimulate the natural positive forces within other people by our relationship with them. And that the crucial elements of that healing stimulating relationship are empathy, authenticity, and genuine positive regard. Think about it. Who do you have in your life who really gets you, tells it to you straight, and likes you anyway? Don't you treasure them and don't you grow and heal around them.

5) Moving from battling with to empathy for drug addicts

I never intended to treat drug addicts. I hate drugs and what they do to people, and I don't use drugs at all. But ignoring addicts, pushing them away, confronting them, shaming them, refusing to see them or medicate them – all the things I was taught - didn't work and they wouldn't go away. When we adopted a "no fail" policy, I had to put away those judgments and approaches and figure out something to do with them besides "discharge from services."

I, like most psychiatrists had to learn both techniques for actually helping drug addicts (even those who do not admit they have a problem, want to stop using drugs, or are willing to go to a program to stop) and make emotional changes to be compassionate and empathetic towards drug addicts.

The technical skills require an acceptance that recovery lies in them, not in us, and of our own powerlessness over substances. We can learn a four stage approach – engagement, persuasion, active treatment, and relapse prevention – and techniques like housing first, harm reduction, and motivational interviewing, but unless we change our underlying emotions we won't use them effectively. In order to really help addicts we need to partner with them instead of fighting them. Then we can stop focusing on confrontation techniques, our fears of manipulation and enabling, and risk aversion.

We may have to work on replacing our moralizing with a medical attitude towards addiction, how everyone uses something to manipulate our pleasure centers, and confront our socially taught "just say no" and "war on drugs" stigma.

Perhaps most importantly, if we can picture them able to recover then we can help them see the possibilities too. That's how we can help create hope. And when we imagine what the addict in front of us would be like if they recovered we'll also see them as someone who will be deserving of our admiration instead of our loathing. And we might even realize that's the same person at a different time of their life as the person we're struggling with now overwhelmed by their addiction.

6) Collaboration with other staff and others

Most doctors are self reliant. We'll "do it ourselves" to make sure it's done right. We learned early on doing group projects in school that if we wanted to get an A we'd have to do it ourselves. Getting into medical school isn't a team sport. Successful strategies include studying alone instead of going partying with others, cutthroat competition, personal drive and dedication, and practice, practice, practice. Doctors are more like tennis players or boxers than team players. Maybe we can accept other people following our orders, but not really being interdependent teammates. In general we don't' listen to others or learn from them. We study and figure it out ourselves.

For recovery services to be effective they need to be team based…including psychiatrists. Teams are needed to integrate a multitude of quality of life services (few people need one thing done well), to match staff strengths with the needs of various stages of recovery, to create a "counterculture of acceptance" for a variety of people who are usually rejected by others, to provide availability and accessibility, to protect our safety and ethics, and to support each other to decrease staff burnout.

Far too many recovery programs are being set up with the psychiatrist apart from the rest of the team. We're too influential, medications are too central, and hospitalizations are too disruptive to keep us separated. I'm convinced that the reason person- centered hospice care is forced to wait until someone is beyond hope of survival, rather than being the treatment approach for initial cancer diagnosis, useful whether someone lives or dies, is because most oncologists won't collaborate with the hospice team. They'll only refer to hospice when they withdraw in defeat. We psychiatrists should be able to do better.

Being part of a team also facilitates psychiatrists' roles evolving as we age and develop rather than all psychiatrists having the same roles and responsibilities regardless of our age. Over twenty years I've gone from being the youngest person on my team to being the oldest. When I was young I used to be very impatient and aggressive and risk taking and trying to learn. Now I'm more philosophical, patient and slower, and more likely to teach. Having a team has helped me be effective instead of one-dimensional as I've developed.

Once collaboration begins there's no reason to stop with teammates. We can collaborate with the people we serve, with their families and friends, with landlords, employers, schools, and policemen. We can collaborate with other social service agencies, doctors, and hospitals.

7) Moving from fixing deficits to building strengths and resilience.

It comes naturally to almost everyone to try to help by fixing what's wrong. All of our cliché doctor greetings – "What's bothering you?" "What's your problem today?" What brought you in to see me today?" – focus on deficits. Even "How can I help you?" rarely means "How can I help you build your strengths so you can be healthier and more resilient to make it through this?"

We spend almost all of our time building problem lists, learning about stressors and triggers for relapse, and defining vulnerabilities compared with the amount of time we spend understanding what strengths they can rely on and what protective factors they have. We analyze their crisis far more than their rebuilding. If we expect to promote recovery and not just maintaining stability and avoiding relapses we need to focus on how they recover as much as how they deteriorate. In my initial evaluations with people I include "I can already see in you the strengths you're going to use to overcome these problems."

In the first six months that we work with someone I no longer focus on racing around fixing all their crisis. Instead I focus on building their protective factors – money, housing, family connections, social support, social roles, and spiritual support. If they get most of those protective factors more often than not, they stop having crisis and hospitalizations.

Virtually all of the people we see will have future symptoms and relapses of whatever their condition is. Recovery doesn't depend on never having symptoms again. It depends on having enough resilience to handle the inevitable symptoms and relapses without them destroying their life again. Recovery is not cure.

The outcome of a successful recovery is not, "I'm so glad I met you Dr. Mark. You really listen to me and understand me. You made a good diagnosis and found meds that really work. You got me benefits and found me a place to live where they take care of me. If I have any problems I know I can always come to you and you'll be there and tell me what to do. My life depends on you." That's not recovery; that's dependent and almost crippled.

The outcome of a good recovery is more like, "I wouldn't have wished this condition on anyone. The suffering and the loss have been indescribable. But it has helped me find strengths inside me I never knew I had. In a strange way it's helped me realize what's really important in life and become the person I am today. There have been gifts from my wounds, and blessings form my struggles."

If we want the people we serve to have different outcomes than we're used to, we have to change ourselves and how we approach serving them.