Psychosocial Rehabilitation: A Newcomer's Eye

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With the increasing emphasis on evidence-based practices and recovery-oriented mental health services, the field of psychosocial rehabilitation for people with serious mental illness has a promising future. A tension exists in the rehabilitation movement—which comprises individuals with mental illness, care providers, family members, and other stakeholders—between those who advocate for recovery leading to full participation in the mainstream and those who call for more modest goals. This tension stems from ideological underpinnings that frequently drive debates about rehabilitation research and program development. This Open Forum proposes a strategy for clinicians to mediate the different perspectives, with an emphasis on flexibility and an individualized approach to clinical care and rehabilitation. The challenges and rewards of this approach for clinicians in training are also highlighted. (*Psychiatric Services* 58:1116–1118, 2007)

Principles of recovery and rehabilitation posit that people with mental illness gain greater freedom by working toward individualized goals, thereby living fuller lives (1,2). It is hard to disagree with such a supposition. The exact nature of the freedom, what a particular individual's goals look like, and what it means to live a fuller life, however, are much more complicated issues (3). As a resident deeply committed to supporting the recovery of individuals with whom I have worked clinically, I have often felt that the nuance in what recovery actually looks like underscores a tension running through much of the rehabilitation movement. For the purpose of exploring this tension more deeply, I will present the two contrasting viewpoints in their most dramatic iterations. I will argue that a middle-ground synthesis of these perspectives is neither possible nor desirable; rather, clinicians require both a flexible and highly individualized approach to clinical care and rehabilitation efforts.

At one extreme of this tension are people whom I will call proponents of full recovery. They argue that a majority of people with severe mental illness can recover and have jobs, relationships, and minimal symptomatology. Such individuals point to evidence of successful programs, the Maine-Vermont longitudinal studies, and powerful individual narratives of success (4–7). They highlight the consumer movement, value personal over professional experience, and argue that existing treatment systems tend to foster dependency.

At the other extreme sit some clinicians, certain proponents of the clubhouse movement, and a handful of individuals with mental illness who feel that some people are unable or prefer not to fully participate in the mainstream. In this conceptualization it is thought that working may simply be too much for some individuals and not worth risking a hospitalization. From this viewpoint, to speak of competitive employment with individuals who feel unable to do more than participate in a less-than-mainstream setting can be not only unrealistic but also invalidating and potentially stigmatizing. Still other individuals might work but prefer to work in a system that understands the difficulties they have had.

How, then, can one reconcile this difference between proponents of full recovery from mental illness with those who advocate something less than full participation in the mainstream? As a resident I had the opportunity to explore the field of psychiatric rehabilitation without all of the helpful experience that often leads to entrenched personal beliefs. The rehabilitation movement appears particularly susceptible to getting subsumed in personal or political agendas. As a newcomer I have had (I think) no agenda except to learn all that I can about different ways of improving the lives of people who live with mental illness.

Recovery and the ideological tensions in rehabilitation

Recovery from mental illness is a highly complex, individualized process. It is my assumption that individuals with serious mental illness can recover and have productive work lives, satisfying relationships, and greater meaning in their personal lives (8). Recovery in this way is best understood as a process rather than an outcome (9,10), and it is highly individualized—that is, what brings meaning in any two peoples' lives will necessarily vary greatly. There is a dire need for our current mental health system to become more recovery oriented (11); this is in part why it is so critical to better understand the

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ideological tensions that I have observed in the rehabilitation field. Psychiatric training involves learning the language and culture of a field; my hope is that, as a recent trainee, my perspectives on tensions within the rehabilitation field can deepen our understanding of where the field currently is, with the goal of helping our mental health systems embody a recovery orientation.

As I have sought to absorb the principles of recovery-oriented services, I have encountered a sense among certain clinicians that some rehabilitation proponents—researchers and advocates alike—are more removed from the very difficult day-to-day life of individuals who may seem unable to "recover" in a meaningful way. Perhaps clinicians feel this way because they do not recognize the individualized nature of recovery, because of the absence of recovery-oriented services or because they have not embraced recovery as a goal. However, these variables aside, it can remain a challenging, nuanced task for a clinician to know where to locate oneself with regard to an individual's steps toward recovery. It is clear that particular goals ought to always come from the individual rather than be imposed by a treatment system. Yet once these goals are identified, there are a range of stances that a clinician or service system might take. How, for instance, should a clinician respond to an individual who identifies work as a goal but who continues to have difficulty sustaining any kind of job? Should such an individual continue to be encouraged to try other work opportunities? Ought the clinician encourage a reassessment of goals and consider recommending a nonmainstream setting for work? How does this change if an individual decides he or she does not want to work after failed initial attempts? Does encouraging such individuals to volunteer, work, or study feel invalidating to the individuals themselves? Might the more empathic stance on the part of the clinician be acceptance of where the individual is? Or is this in fact paternalism?

This tension between these two viewpoints is not novel. A similar tension existed in the development of social and housing supports for the homeless alcohol-abusing population in Boston (12). One set of advocates for the homeless believed that a shelter should be a nonjudgmental respite where people are accepted as they are, whether ready to get sober or not. On the other side were the proponents of bringing social services to the shelter's basement to provide residents with skills and supports to achieve sobriety and independent housing. The arguments in the field of psychiatric rehabilitation are not dissimilar. The stridency of both sets of advocates suggests that beneath the surface of discussions about psychiatric rehabilitation are big issues of paternalism, individual rights, psychiatry's therapeutic limitations, and the injustice in the lots we are all dealt in life.

Bringing two viewpoints into practice: dialectical extremes

As I have sought to immerse myself in this field, I have found these two extremes quite confusing at times. Training typically involves a long period of time in which we trainees do not feel at all confident about what we are doing. Most of us, I think, are pretty eager to grasp onto something once we start feeling the slightest bit proficient. However, I have come to believe that my feeling of not being totally grounded in a clinical encounter might in fact be good, even if it might not feel that way at the time.

A slightly different consideration of the divergent views of rehabilitation, using the lens of individual differences more broadly construed, is a helpful perspective. At one extreme is the acceptance of individuals' differences, which has led to disability rights movements in which a person's difference is embraced as a valid, other way of being in this world (13). This can be an important process in terms of political rights, an individual's sense of self-worth, and group cohesion. Taken to an extreme, however, it can foster the maintenance of separateness from mainstream society and a lack of engagement in a pluralistic community. At this extreme it might also require an unrealistic amount of resources from society to adapt to an individual's particular circumstances.

Similarly, mainstreaming can also be taken to its extreme, in which a person's legitimate differences and assets are ignored in the interest of the homogeneous middle. In this instance, valid but different ways of approaching situations are sacrificed to a middle-ground approach. Risks in this setting include trampling on the individuality of people with a valuable "other" perspective, as well as a loss to society of what this other perspective has to offer to the mainstream (13).

Once presented in this manner at their most extreme iterations, the tension between these two sets of philosophies and ideologies evokes a dialectic analogous to that at the center of dialectical behavior therapy (DBT)—that is, between acceptance of where one is while simultaneously acknowledging the need to change and grow (14). The principles of DBT are quite helpful in navigating between the two perspectives on psychiatric rehabilitation. DBT does not attempt to help individuals find a new single middle ground. Rather, the conceptual underpinning of DBT specifies that an individual simultaneously hold both sides of the dialectic and use flexibility in moving along a continuum as circumstances dictate.

What implications might this have for psychosocial rehabilitation? It suggests, I believe, that an important aspect of navigating these complicated waters is maintaining an acute awareness of the tension between these two ends of the spectrum. This does not suggest that the differences should be resolved by finding a new middle ground, but rather that clinicians must be flexible in moving around the continuum over time. A treater might, for instance, vacillate from leaning toward one pole to leaning toward the other, with the goal of holding onto a sense of tension about the proper place to locate himself or herself while taking into account individual patients' goals and limitations.

As a trainee it can be challenging to try to find a foothold in this fluidity and to be conceptually mobile in this

way. Yet I believe that fluidity over time, with all of its messiness and discomfort, is precisely what is needed. With a flexible stance a clinician might argue for an individual's need for treatment at one moment in time and at another moment might talk with this same individual about vocational goals. Also important is the approach of shared decision making, which has the potential to maximize client autonomy while making the clinician better informed about clients' values, preferences, and experiences.

Toward the future

The field of psychosocial rehabilitation has a bright future, and it is exciting to anticipate the field's potential for tremendous gain from the increasing emphasis on evidence-based practices and recovery-oriented mental health services. Psychosocial rehabilitation has traditionally had difficulty attracting residents. My hope is that my observations made during training and detailed in this Open Forum might convey to other young psychiatrists how I have navigated what has struck me as complicated about the field. And it is perhaps what is complicated that is simultaneously what is so compelling —how passionate rehabilitation experts are, how early in its development the relevant research is, and how inspiring it is to envision a more recovery-oriented mental health system. In the face of a pervasive sense of burnout and bitterness in so much of medicine, psychosocial rehabilitation counters with the potential to be both intellectually stimulating and personally gratifying.

It is easy to feel deluged by the powerful, sticky ideologies driving the two sides of the rehabilitation dialectic. The field's tendency to get mired in ideological disputes can at times detract from what most of us agree upon: the possibility of recovery from even the most difficult of situations, the importance of supportive relationships and communities, the belief that quality of life for those with serious mental illnesses can be improved, and the need for us to better understand what we do. Although we can learn a great deal from examining the ideological extremes, there may be no middle ground that will mediate their differences. Rather, they represent perspectives that can be brought to bear to greater or lesser degrees at different moments in time. The sorts of insights that they lead us to are valuable in part because of their differences. For psychiatrists in training, this sort of complexity can be challenging and confusing but ultimately enriching.

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