

Implications of the Shift from Diagnosis and Treatment to Recovery and Resilience for Research and Practice

Edith Henderson Grotberg, Ph.D.

Georgetown University. Washington, D.C. USA

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As members of the International Council of Psychologists (ICP), we are constantly aware of changes in thinking, training, policy, and practice, that occur over the years of our careers. This is especially true in the field of mental health, which, despite organizing into specialties, is an overarching focus of our profession. And it is the impact of the shift from diagnosis and treatment to recovery and resilience on the mental health of those we serve that is the concern here. Several questions immediately form in response to this shift.

What has the shift done to our understanding of mental health? What has it done to supporting research and programs? What has this shift done to provider/client relationships? And germane to each question is: What are the strengths and weaknesses of the shift?

While I am aware of what many countries are doing in answering these questions, and have witnessed, even participated in the formation of some of the policies, I feel qualified only to talk about what is going on in the United States. I trust you will find our experience helpful to you as you conduct research or engage in practice in your country.

What has the shift done to our understanding of mental health?

Most nations think in terms of the health/illness dichotomy; therefore, it is not difficult to understand why mental illness became the opposite of mental health. And it is the concept of illness that guided how people with mental and emotional problems were perceived and treated. They were obviously ill; their symptoms needed to be treated and managed. In short, the medical model, with its major focus on the health/illness dichotomy, became the guide for treatment and management of those with mental health problems. However, in many ways mental health has been perceived with an inordinate number of negative thoughts and feelings, all tending to view mental illness with stigma.

In the Executive Summary of the President's New Freedom Commission on Mental Health, 2003, stigma is defined as a "cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses. Stigma leads others to avoid living, socializing, or working with, renting to, or employing people with mental disorders - especially severe disorders, such as schizophrenia. It lead to low self-esteem, isolation, and hopelessness. Responding to stigma, people with mental health problems internalize public attitudes and become so embarrassed or shamed that they often conceal symptoms and fail to seek treatment." p.5 (www.MentalHealthCommission.gov).

That limited view has been challenged over the years in the United States, with many researchers and practitioners recognizing the limits of the view. However, it took the Report of the Commission to formally and politically recognize new views of mental health and to formulate new policies for future research and services. Two major new policies may be identified as:

1. Recovery and resilience will replace and/or modify treatment and management of mental health problems.
2. Growth and development will replace and/or modify medical and public health models.

It is important to note the implications for research and practice of these shifts. However, it is probably useful to define the concepts of recovery and resilience. Most of us are already familiar with the definitions of diagnosis, treatment, and management.

Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in a individual's recovery.

Resilience means the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses - and to go on with life with a sense of mastery, competence, and hope. We now understand from research that resilience is fostered by a positive childhood and includes positive individual traits, such as optimism; good problem-solving skills and treatments. Closely-knit communities and neighborhoods are also resilient, providing support for their members. pp.5-6

Implications for research and programs

Those involved in conducting research or in developing and carrying out programs are inevitably influenced by the limits of public policy as well as by the practices that have evolved over decades. With changes in thinking and changes in policy, there must be changes in research and programs. The interesting facts are, however, that new views

have been available for more than ten years. For example, the evidence on the importance of resilience in the lives of individuals, families, and communities, has been available for years. Change is difficult. It threatens cherished views; it suggests that what is going on is not in the best interest of recipients of mental health services; it challenges the medical and public health models of waiting for problems rather than anticipating and preventing them; it questions the common practice of protection against negative effects of problems rather than empowerment to deal with them; it requires change from a focus on problems to a focus on human growth and development. Let me illustrate with the public health model.

The public health model has a long and important history in the United States. However, The Centers for Disease Control and Prevention (this last added only in 1998) is focused primarily on protection from disease or other threats to health. The Centers rely on numbers of a problem to determine if action is needed. This works well for diseases and other threats to health. However, when the Centers became concerned about youth behavior, which emerged when the word Prevention was added to the title in 1998, they drew on the policy of counting the number of incidences of problems related to youth behavior in order to determine when action should be taken. For youth, the counting was for teen pregnancy; HIV/AIDS; condom use; tobacco, alcohol and drugs; physical activity and nutrition: obesity; and violence.

The problem with this approach is its limited ability to include problems youth identify as causing some of their anti-social behavior as well as their sense of vulnerability, that often leads to mental health problems. When surveys of youth were made by the

Institute for Mental Health Initiatives, Washington, DC (2002), these were the concerns youth identified:

No help as they fail in school

Conflict with authority figures

Problems of abuse at home

Rejection or discrimination by peers

No one to talk to

No knowledge of how to access services.

Advanced students added:

Not enough time with parents

Too much pressure to succeed.

And when Latino youth, often immigrants, were asked to identify the problems they dealt with, they provided this list:

Racial tensions between different ethnic groups

Conflict with other youth and with adults

Low self-esteem

Difficult relationships with the police

Family problems -abuse, single parent, poverty, drugs and alcohol use by parents

Abandonment

Self-inflicted violence

Bullying and rejection by other cultural groups

Labeled as 'geeks'

Limited opportunity for acculturation

Difficulty finding work, or being exploited in jobs

Identity problems - shift from family to peers and inter-generational conflicts

Lack of time with parents and pressure to succeed.

This disconnect between prevailing public policy and the reality of problems leading to impaired mental health has been challenged. So that today, even the Centers for Disease Control and Prevention have added a great deal of information on their web site to help parents and service providers as they promote the growth and development of children. It should be pointed out, again, how recent that shift has been, beginning only in 1998.

What has the change done to provider/client relationships?

There is a long history of concern about provider/client relationships. Is the client to be a passive recipient of advice and medicine? Can the client challenge the provider without risking rejection? We all know there are inevitable conflicts of clients with service providers, and these conflicts can interfere with successful results. Services have a long history and have developed a culture that is not necessarily consistent with seeking successful results. Here are four conflicts that may well act as obstacles to successful results:

1. The provider seeks cure; the client seeks care
2. The provider focuses on the language of the profession; the client focuses on non-verbal behavior, such as attitudes, attention, empathy, acceptance, and concern
3. The provider focuses on management of the client to follow procedures and wants compliance; the client wants and needs to be seen as a participant in decision making and does not want to feel controlled

4. The provider uses the language of the profession; the client does not understand the language or is intimidated by it.

But, a whole new issue was raised when the President's Commission on Mental Health presented the following goal: Mental Health Care is Consumer and Family Driven. That goal reflects a long history in the area of special education, where parents work with school personnel to agree on an education program for their children needing special education. This program has been in action for decades. However, the Commission recommended not only that consumers and families should dominate in developing a process of recovery and resilience, but that consumers and families have the right for money to follow as the consumer seeks help. The Report states: "By allowing funding to follow consumers, incentives will shift toward a system of learning, self-monitoring, and accountability" (p.8).

My first reaction when reading that sentence, was, "They've got to be kidding!" Why would the Commission imply and change from the domination of the professionals to the domination of the clients? That raised the issue of a power struggle again, rather than a new level of cooperation. And the very next day I read in the Washington Post (November 15, 2005) that the issue in a special education case had reached the courts. The article read: "In a case involving the Montgomery County schools, the Supreme Court ruled yesterday that parents of special-education students disputing proposed instructional plans for their children have the burden of proving why the plans are inadequate, putting the onus on parents, which is the practice in most states" (p.A1)

Some states, however, continue to put the onus on the school - the school must prove the adequacy of its special-education plans when challenged by parents.

It seems quite clear that the issue of who is responsible for recovery and resilience plans will need further consideration.

Problems in forming and carrying out policies impacting on research and practice

States and communities, many of which already have made changes in providing services to those with mental health problems, are attempting to incorporate the Commission's recommendations that focus on recovery and resilience. The example of the State of Ohio illustrates the issues related to that effort.

In an article, *Resilience and Recovery: Changing Perspectives and Policy in Ohio*, Focal Point (Summer, 2005) Research, Policy, and Practice in Children's Mental Health. (www.rtc.pdx.edu), there is a clear description of the problems faced by a state where groups of people wanted to change policy but encountered resistance. The focus in services for children with mental and behavioral health problems had been on recovery. But, the families and service providers had problems with this because it implied going back to a time before the mental illness. And that suggested to them, going back in development to the age where the mental illness began. Clearly, the children were older and needed not to "restart the developmental process at age three, (when they were now age 6) but to recoup those years as part of the process of moving ahead" (p. 25) Resilience captured that vision best.

As a result, family advocates felt it was essential for the state to place resilience on an equal footing with recovery as a guide for mental health policy and practice. However, initial attempts to get the state to recognize the importance of the concept of resilience were not particularly successful. But with the publication of the final report from the President's New Freedom Commission, changes began to be made. The changes

included holding a series of forums throughout the state, and inviting parents and youth to attend along with policy makers and providers of services. Here is an assessment of these forums:

What was learned during the forums was wonderful and also surprising. One might expect that folks would give most attention to the service system or the lack of services. They did comment on services, but what was surprising to the facilitators of the forums was how much of what the youth and families said could have come straight out of a book on developmental assets. They were talking about the importance of having an adult just to talk to, the importance of supportive relationships in the family, and the need to feel a sense of acceptance and belonging at school and in the community. (Focal Point, p. 26)

The pressure on the State for change came in the development of the Resiliency Ring, a public relations event organized by family advocates. The event included “personal visits to every legislator, providing an overview of findings from resiliency studies and talking about the policies and issues that tie into a resiliency framework.” p. 26. (Try to resist that!)

Implications for ICP members

Members of ICP represent some 50 countries, and, clearly, different countries have different policies concerning the mental health of their people. However, there are some issues that all psychologists need to face as new knowledge suggests changes in policies and practices. One common issue concerns the need for a *vision* that reflects the goal of mental health services. The Commission provided such a vision in its report:

“We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are

detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports - essentials for living, working, learning, and participating fully in the community” (p.1).

Every psychologist, no matter which country is home, has a goal, a vision, for his or her services that is shaped by training, experience, values, and cultures. What is being suggested is that the country or some geographic entity, adopt or accept such a goal or vision. Psychologists can help in defining it.

Another obstacle to a coordinated, comprehensive concern about mental health services is *competition*. And the competition starts in the schools; especially in the colleges and universities, where departments, with different foci, are placed in competition for students and resources. Even within a department there is competition for students and resources. And as people seek services, they are confronted with the results of this competitive model. There are few comprehensive service offices available. And, of course, competition extends to the government levels, where money and staff are also in limited supply.

A third obstacle that needs to be overcome is *policy*. Policy reflects the general thinking of a group or a nation. In the United States, policy is generally formed around specific problems, like cancer, youth violence or depression. This problem focus tends to ignore the multiple forces impacting on people. I should point out that Argentina, by contrast, focuses on the community; and policies are established to impact on an entire community, not just a specific problem. Their incorporating resilience into the training programs for all service providers is an example.

Conceptualizing a New Path

If the goal of recovery and resilience is to be achieved, then there is a need to conceptualize a new path to achieve that goal. The process would include the following steps:

1. Clarify the goal(s) in terms of expected results
2. Determine and describe the current status of the various contributing fields and services
3. Suggest needed changes and new concepts that would lead to the goal of recovery and resilience
4. Integrate the results with suggestions for general use
5. Determine dissemination options, including publications, forums, conferences, etc.

This is a challenge for all psychologists and my belief is that ICP members will be at the forefront of accepting the challenge and translating it into action.