

Recovery from psychiatric disability and personal autonomy

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Summary

Several subjective and objective indicators mark recovery from psychiatric disabilities. One of these markers, frequently mentioned in the literature, is autonomous decision-making of a disabled person. The purpose of this article is to show when personal autonomy is and when is not congruent with functional recovery from a psychiatric disability. The author also provides examples of clinical interventions, which are intended to help a disabled person move both toward greater autonomy, and toward improved functioning in a daily life.

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PERSONAL AUTONOMY AND ENGAGEMENT IN TREATMENT

Self-determination and the right to liberty are fundamental principles in democratic societies. Respect for a person's autonomy is also a central value in supporting persons with psychiatric disability. Not all in the psychiatric profession share this value. For example, the report of the National Bioethics Advisory Commission maintains a rather stereotypical and potentially stigmatizing view of persons with severe psychiatric disability as "permanently and globally impaired" in decision-making due to their psychiatric diagnosis. Contrary to this view, empirical evidence suggests that impairment decisional capacity is not a distinguishing feature of schizophrenia [1]. It is quite possible that psychiatrists treating persons with severe and persist-

ent symptoms in institutional settings assume that their patients represent a broader population of patients with the same condition. In reality, persons, who manage their conditions adequately in the community, are less like to seek psychiatric care and practitioners commonly see patients with a more severe disability and less coping skills [2]. The same "clinical bias" may explain why a person's reluctance to become engaged in mental health treatment is often attributed solely to the lack of insight [3]. Such a narrow clinical perspective excludes other common reasons for treatment non-adherence, such as poor access to care system, negative experience with a mental health practitioner, past history of involuntary treatment, or disabling effects of medication therapy [4]. Ironically, persons with a psychiatric disability at times show good judgment by choosing to avoid substandard care. In addition, there is a crucial difference between the lack of decisional capacity and a disagreement between a patient and his doctor. For example, persons undergoing medication treatment may understand relevant information about recommended medication, be able to apply this information to his or her situation, consider both ben-

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efits and risks of a particular medication, and choose not to take it. Considering that typical outpatient appointments for medication management in Oregon usually last no more than fifteen minutes and do not leave much time for a dialogue, reluctant patients are likely to be labeled as “lacking insight.”

PERSONAL AUTONOMY AND PSYCHIATRIC DISABILITY

Another look at personal autonomy from the philosophical perspective highlights the following factors:

- being a person who is calling the shots;
- being able to make up our mind;
- being accountable for what we do;
- being aware of our intentions when we act;
- trusting our judgment about how to act [5].

On the other hand, psychiatric disability is often manifested by:

- psychiatric symptoms grossly and persistently interfering with activities of daily live;
- functional limitations in social skills affecting person’s work, education, social and family relationships, and independent living;
- cognitive impairments which are present even when acute psychiatric symptoms are in remission;
- dependence on institutional care [6].

Comparing these two concepts with each other must raise questions about the barriers, which are likely to prevent a psychiatrically disabled person from engaging in an autonomous action. These barriers are both internal and external. Internally, decisional capacity may be temporarily impaired by the severity of positive and negative symptoms, stressful life events, or receiving higher doses of medications that may adversely impact cognition. It is also important to remember that self-stigmatization may cause persons with psychiatric conditions to distrust themselves, and view themselves as objects rather than as subjects. External conditions limiting freedom of choice include poverty, social stigma, limited access to affordable, permanent housing, barriers to regular employment, legal commitment to involuntary treatment, or controlled ac-

cess to personal funds when managed by a designated representative payee. Benefits programs based on the concept of “total and permanent disability” may also create barriers for persons who want to achieve more autonomy.

PERSONAL AUTONOMY AND RECOVERY

Recovery is sometimes narrowly defined as a sense of empowerment to make your own decisions without necessarily achieving stable remission and functional capacities. Subjective definition of recovery inadvertently implies “feeling good” about following activities scheduled by others, having shopping done by a paid caregiver, money and medication managed by others, and working in a sheltered employment setting. Personal choices may also include eating only junk food with no limits despite morbid obesity, napping all day long, or refusing all mental health services at the time of need [6]. Obviously, exercising freedom of choice without good judgment may lead to numerous problematic behaviors. In order to avoid the risk associated with the subjective conceptualization of recovery, Liberman formulates a normative definition based on the objective criteria [7]. This objective definition of recovery consists of the following empirically testable indicators:

- freedom from distressing psychiatric symptoms;
- lengthy period of community living without daily supervision of money, activities of daily living, and medications;
- working or studying in integrated settings;
- having satisfactory social contacts with family and peers;
- capacity to problem-solve even under stressful conditions
- participating as a citizen, in voting and other civic areas
- collaborative engagement with trusted mental health professionals.

There is no doubt that the objective conditions of recovery reflect common societal norms. Not everyone must endorse such values as having a family, paid job, or performing civic duties. For example, a homeless man once argued eloquently to the author that he was more proud by sur-

living on the streets of Portland that he would have been by working in a large corporation. To use another example, people calling themselves “psychiatric survivors” reject any form of collaboration with mental health practitioners and seek support from their peers instead. Briefly speaking, the list of objective conditions of recovery doesn’t fit everybody. On the other hand, the author observed that many patients residing for years in mental health institutions dream of a “good life” in ways reflecting common societal values. They often speak about not wanting other people to always tell them what to do, about having their own family, own house and a paid job. Unfortunately, for many institutionalized mentally ill individuals, these “normal” life aspirations appear hopelessly out of reach. This is at least one reason why it makes sense to keep the objective criteria of recovery in mind even if they are necessarily universal.

CLINICAL STRATEGIES IN SUPPORT OF PERSONAL AUTONOMY

Social skills training is an example of the empirically validated strategy of improving a person’s interpersonal and independent functioning. It also increases a person’s self-confidence in the autonomous decision-making process. It involves systematic teaching of social behaviors through a combination of modeling skills, role-playing, providing constructive feedback, and practicing skills in natural situations. This psychosocial intervention, although hardly a “silver bullet”, when tailored adequately to individual needs, has proven to increase patients’ independence and even reduce the dose of medication required to protect a person from a relapse [6]. General skills training strategies include:

- using motivational and cognitive interventions to resolve ambivalence for change;
- helping a person set up personally relevant, functional and realistic goals;
- exploring with a person’s barriers in achieving these goals;
- planning incremental steps to remove these barriers through progressive skills development;
- ment in skills development;
- demonstrating and practicing new skills;
- teaching problem-solving to overcome obstacles to use skills in real life situations;

- addressing skills most likely required during and after transition to new, more demanding life situations with greater autonomy.

It is worth mentioning that social skills training is a very directive approach, which is temporarily limiting a participant to “how” and “when” practice skills rather than “if”. However, this directive teaching style is used deliberately to overcome patients’ passivity and to ultimately offer them the tools necessary for a truly autonomous action.

It is also important to add that supporting persons with a psychiatric disability in their journey toward greater autonomy requires, in addition to social skills training, several other elements, best described by Falloon in the International Study of Optimal Treatment for Psychosis [8]. Such optimal strategies should include:

- Antipsychotic medication strategies targeted at changing symptom profiles
 - choice of medication based on symptom profiles, side effects and response;
 - adherence training and maintenance;
 - illness management training;
- Education of patients and informal caregivers in stress management strategies
 - education to enhance understanding of the nature of psychotic disorders and their clinical treatments;
 - training in interpersonal communication and problem solving to achieve personal goals and manage life stresses;
- Assertive case-management
 - development and maintenance of effective social supports - housing, finances, health and safety;
 - resolving clinical and social crises in the settings most conducive to full and rapid recovery;
- Occupational Support
 - supporting patients to access social and occupational opportunities available in their communities;
- Specific techniques for managing residual or emerging symptoms
 - persistent psychosis and negative symptoms, anxiety, mood swings, anger, suicidal

thoughts, substance misuse, sleep disorders and nutritional problems.

Unfortunately, for a variety of cultural, organizational and attitudinal reasons, evidence-based psychosocial interventions, even when they are packaged in simple to use UCLA modules, are much harder to disseminate in routine clinical settings than pharmacological therapies [9].

SUPPORTING PATIENTS' RECOVERY WITH RESPECT FOR THEIR AUTONOMY

Finally, the author proposes a set of principles to guide practitioners, who irrespective of their discipline and credentials, are engaged in supporting persons recovering from a psychiatric disability in ways that are consistent with supporting patients' autonomy. These principles are sometimes taken for granted. In this article they have been formulated as a credo of the profession:

- we manage our mood, motivation and behavior deliberately in a service of patients' needs;
- we show respect to patients by being polite and non-judgmental, by spending sufficient time with them, keeping promises, and seeking reasonable compromises whenever possible;
- we emphasize our common humanity and break down artificial barriers between ourselves and patients;
- we create a treatment environment in which every patient can safely practice skills and have an opportunity to succeed;
- we believe that with the proper support, even the most disabled patients can make constructive changes in their lives;
- we infuse patients with our hope and realistic expectations for incremental improvement;
- we attend with great care to basic needs of patients out of respect for their personal dignity;
- we constantly adopt state-of-the-art and empirically proven clinical interventions;

- we verify our perceptions by reference to concrete outcomes and by using objective measures to assess their progress.

CONCLUSION

The conclusion of this article is very simple. Personal autonomy without functional recovery is an empty slogan. Persons with a psychiatric disability require skills and supports provided by a comprehensive array of rehabilitation services in order to truly exercise their autonomous choices, like other citizens in a democratic society.

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