

Interview

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Kim T. Mueser, Ph.D. was recently appointed Executive Director of the Center for Psychiatric Rehabilitation. We interviewed him shortly after his arrival and below are excerpts from that interview.

Q: How did you get in to this field?

Kim: As you know, I am a clinical psychologist. My first knowledge of psychology as a field was actually at the age of 10 or 11, when my mother got a job teaching Psychology at a Junior College. Some of the topics that her students tackled just struck me as very intriguing.

After teaching for a few years, my mother obtained a job at a local state psychiatric hospital in the late 1960's, working on one of the "Back Wards". There was a lot of excitement at the time about the development of new interventions and treatments, especially social learning based interventions for people with a serious mental illness.

My mother began trying new approaches to treatment and actually developed one of the first Token Economy programs in New Jersey where individuals, living in the hospital, were rewarded for socially appropriate and self-care behaviors that could enable them leave the hospital. In my early teenage years I went to



the hospital with her and met the individuals who lived in the community and who were patients there.

Q: At some point there was criticism that the Token Economy which was based on B.F. Skinner (research on operant conditioning and views on creating a utopian society) was seen by some as too mechanistic.

Kim: I do believe that it is possible to look at things too mechanistically. But it is also possible to pretend that your behavior is not being influenced at all by your environment. When B.F Skinner wrote the book Walden Two he was exploring how the consequences of our behavior influence our behavior. He believed that awareness of this can actually lead us to create a more humane and more caring society.

Gordon Paul conducted a classic study on the Token Economy in the

early 1970's, at a psychiatric hospital in Illinois. The Token Economy is an intervention that created a very structured environment in which performing desirable behavior earned certain tangible rewards through a point system or earning tokens. He studied three differ-

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ent treatment programs: (1) treatment as a usual; (2) milieu therapy which was highly intensive with lots of different activities, but not focused on social learning, and finally (3) a Token Economy program.

Patients who were in the two active treatments (Milieu and Token Economy) did much

better than those who received the usual treatment. However, the Token Economy program was much more effective than either of the other programs in getting people discharged from the hospital. A significant number of the patients were actually discharged from the hospital without the need for medication!

On the one hand, people who were interested in studying Skinner could be blamed for not seeing the "personal" or "person" as relevant to recovery; but on the other hand, the goals of the Token Economy of helping people develop more adaptive skills for self-care and interacting with others were what really helped people take control and power over their lives.

It was found that this important technology help people achieve those personal goals and leave the hospital after many years of institutional living.

Q: There seems to be some controversy over the definition of *psychiatric rehabilitation*. Do you feel that

professionals can have different views about its definition without it being a problem in the field?

Kim: I do think it's possible. I'm a "big tent" kind of person which means that I have a high tolerance for differences in opinion and perspective in other people if I believe we share the same goals. I don't believe that it is important that there be one unified definition of psychiatric rehabilitation. Different definitions can co-exist in one field. In my opinion, it is even to be expected that there be various definitions since people differ in how they conceptualize and think about psychiatric rehabilitation.

My interest has been in finding what works in terms of helping people function better and achieving goals like independent living, rewarding social relationships, interesting work, enjoyable leisure activities, and spiritual involvement. To me, those are goals we think of as recovery, and they have really been the goals of psychiatric rehabilitation all along.

Because I've been focused on those outcomes as well as helping people manage symptoms and related challenges, there's never been a strong need for me to make the distinction between rehabilitation and treatment. Sometimes when you're doing things to help people, you need to avoid the word "treatment" because some people aren't supposed to do treatment. And so, in those cases, I tend to work around the word because I don't want people to not be able to learn ways of helping other people achieve their goals and progress in terms of recovery just because someone is



not allowed to be doing certain types of work. So, for example, the **Illness Management and Recovery Program**, we don't call it a treatment program and we don't say you have to be a clinician to implement it. If you explore how to implement the program, you will find that there are lots of cognitive behavioral strategies that people can learn in order help others. We just don't call it behavioral "therapy".

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One reason for distinguishing between rehabilitation and treatment is that, traditionally, treatment has been thought of in terms of medical treatment, which has focused only on the symptoms of the illness.

So, if you break a leg, the "treatment" is focused on repairing the break (immobilizing the leg, putting a cast on so the break will heal). The process of learning to walk again is the rehabilitation process. In that way, sometimes the distinction is made between the treatment of the symptoms of a disorder and the restoration of functioning.

I think that this distinction between treatment of symptoms and restoration of function can be useful for physical disorders, but doesn't work as well for psychiatric disorders. In contrast to medical disorders, psychiatric disorders usually incorporate the functional impairment into the definition.

Even if you make a theoretical distinction between rehabilitation and treatment, one focusing on functioning and the other focusing on symptoms, in practical terms many programs seek to integrate the two because that's the most effective way of accomplishing each one, making it difficult to maintain a distinction.

Kim T. Mueser, Ph.D. is a clinical psychologist and the Executive Director of the Center for Psychiatric Rehabilitation at Boston University.



Dr. Mueser's clinical and research interests include family psycho-education, the treatment of co-occurring psychiatric and substance use disorders, psychiatric rehabilitation for serious mental illnesses, and the treatment of post-traumatic stress disorder. His research has been supported by the National Institute of Mental Health, the National Institute on Drug Abuse, the Substance Abuse and Mental Health Administration, and the National Alliance for Research on Schizophrenia and Depression. He is the co-author of over 10 books and treatment manuals, and has published extensively, including numerous peer reviewed journal articles and book chapters. Dr. Mueser has also given numerous lectures and workshops on psychiatric rehabilitation, both nationally and internationally. He has also published prolifically. Recent publications include:

*Aschbrenner KA, Mueser KT, Bartels SJ, Pratt SJ, "Family contact and health status among older adults with serious mental illnesses." *Psychiatric Rehabilitation Journal*, 2011 Spring; 34(4):295-303*

*Mueser KT, Pratt SJ, Bartels SJ, Forester B, Wolfe R, Cather C. "Neurocognition and social skill in older persons with schizophrenia and major mood disorders: An analysis of gender and diagnosis effects." *Journal of Neurolinguistics* 2010 May; 23(3):297-317*

*Mueser KT, Taub J "Trauma and PTSD among adolescents with severe emotional disorders involved in multiple service systems." *Psychiatric Services Journal*, 2008 Jun; 59(6):627-34*

For list of publications and more information see <http://cpr.bu.edu/about/directory/kim-mueser/>

Q: As you talked to lay persons in the community, what do you see as the biggest misconceptions right now?

Kim: The biggest misconception is that psychiatric disorders cannot be treated effectively, and

that people with a mental illness can't achieve their goals or live meaningful and productive lives.

My belief is that there is so much fear about mental illness in part because people don't realize how many effective tools we have to treat these disorders, and the fact that people are able to live worthwhile, fulfilling lives despite having a mental illness.

There are two things that I like to do whenever I provide a public lecture: One is familiarizing people with different types of mental illness because it helps people conceptualize and recognize common symptoms and problems. The second is to provide information about effective treatment for mental illnesses.

The exciting thing is that, especially when it comes to the treatment of serious mental illnesses such as schizophrenia, severe major depression, and bipolar disorder, we've learned a tremendous amount in the last twenty-five years. And most of what we have learned has been in the area of psychosocial treatments and rehabilitation.

Understanding how much we have learned in this field

I believe that if we provide information to people that mental illnesses can be treated, recovery is possible, and that people with a major mental illness have basic human rights that the disparities in terms of getting help and insurance coverage will become more of a focus of public concern, and even outrage.

is critical to people with the lived experience of mental illness, as well as for their family members seeking and obtaining treatment. If you believe that a problem or disorder is not treatable, then denial of the

problem and refusal to seek treatment are very understandable responses. But if you believe that a problem or disorder is treatable then you have hope, and it naturally follows that you get treatment.

Another reason why I think public education is important is the discrimination people with mental illness face compared to other medical illnesses. The disparities in terms of getting help and insurance coverage are good examples. Medical insurance does not cover the cost of treating mental illness as well as it covers physical illnesses.

I believe that if we provide information to people that mental illnesses can be treated, recovery is possible, and that people with a major mental illness have basic human rights, that the disparities in terms of getting help and insurance coverage will become more of a focus of public concern, and even outrage.

Public education about what mental illnesses are, and how to treat them, has the promise of decreasing stigma and increasing opportunity, empathy, and understanding. Those things go hand in hand with each other.

The Repository of Employment and Vocational Recovery Resources is now available at:

<http://www.bu.edu/cpr/employment/>



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