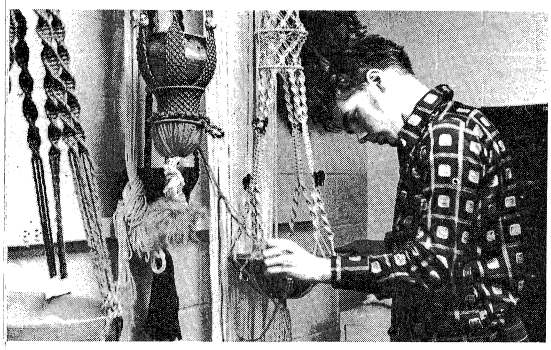
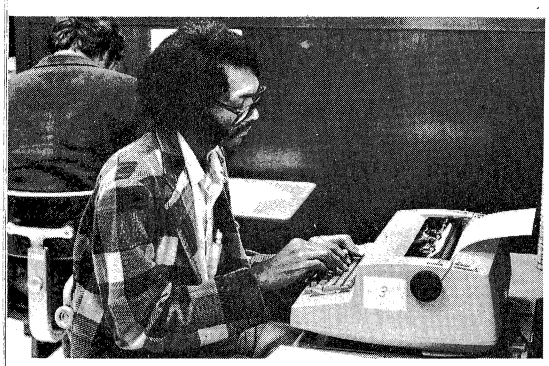
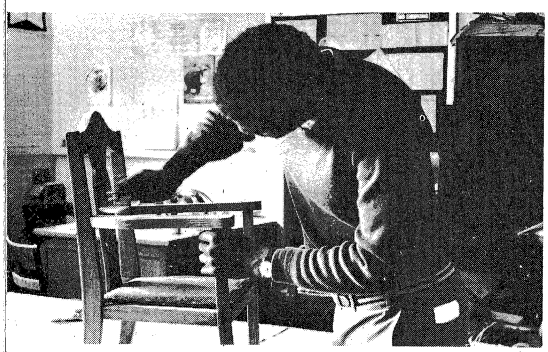
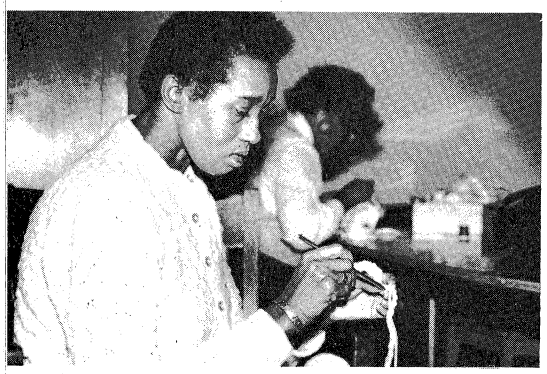
U.C.'s Rehabilitation Center helps disturbed adults leave the twilight zone of social inadequacy and regain their birthright as

Real people









THE PEOPLE WHO get admitted to Dr. Julian Myers's program are all special people; special because they are socially inadequate, desperately in need of help adjusting to the world around them, after spending long periods in institutions that have robbed them of what the world calls "normality."

Myers is Director of the University of Cincinnati's Rehabilitation Center. He also wears two other caps—he's Professor of Psychology and Coordinator of Rehabilitation Counseling. It is to the Center that the special people are admitted. Myers refers to his charges as "trainees."

"Ours is indeed a training program," he says. "The people who come to us are not patients; they are trainees, and it is important to get away from a medical frame of reference implied in the word 'patient.'

"Once you've been institutionalized you begin to lose your social footing. Over a long period of time, you lose whatever adaptive skills you had. Somebody takes care of you all the time and you assume less and less responsibility."

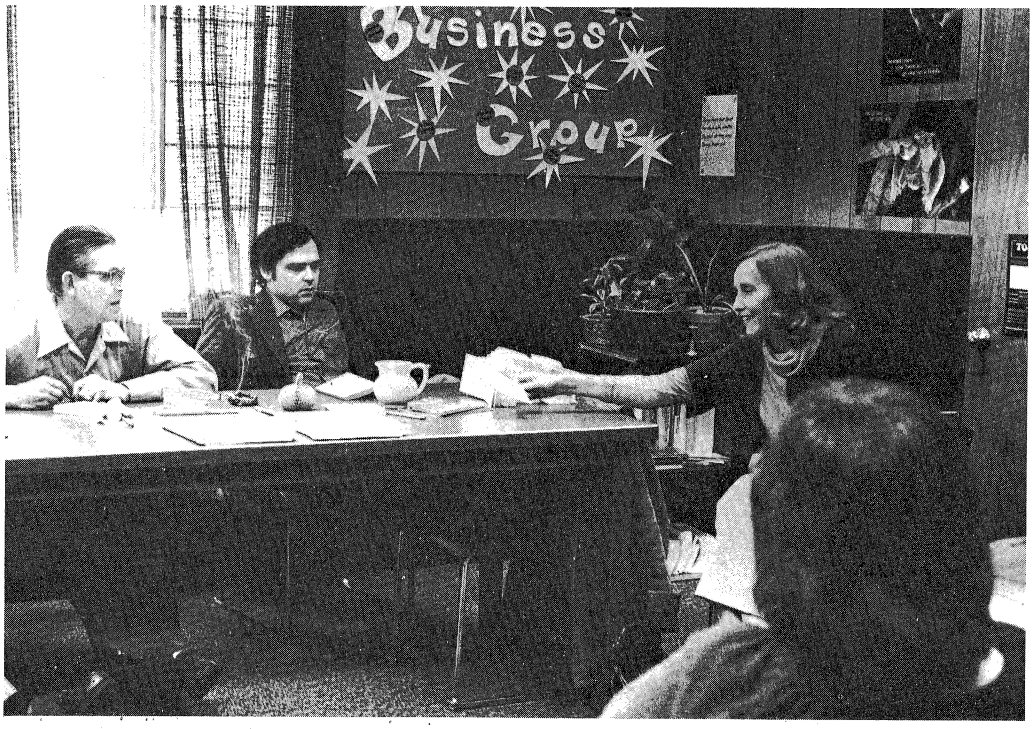
Rehabilitation for the trainees differs from that for people suffering physical disabilities; trainees are socially dysfunctional, and they are exposed to a gradual sequence of activities aimed at developing coping skills, self-confidence, emotional stability, social skills, and better attitudes toward themselves and others.

Typically, trainees are between eighteen and twenty-three and have simply missed out on the socialization process in youth. They haven't learned to live up to social norms, rules, and regulations. They are often intellectually limited and their social development was usually aborted at an early age because they came mostly from broken homes, frequently poverty-stricken. Many have never known stability and usually have not had adequate role-models in their parents. Generally, the total motivation system of such children revolves around survival, rather than preparation for adult roles. They get accustomed to surviving in the streets or in institutional settings. But their personality development is halted; social roles, work skills, reading and writing competence are not developed. At some time in their growth they stop learning how to get along with people; they may become indifferent to cleanliness and dress—and often end up in institutions because of combinations of arrested mental development, exhibited in primitive forms of behavior and asocial habits.

If these people are released from the institution to the street, they cannot cope. They are back in the institution in no time.

Says Myers, "There's a big wave of 'de-institutionalization' (a euphemism for throwing them out on the street) currently. Mental patients are simply dumped into the community with little or no preparation on their part or on the part of the community."

Myers declares that the typical treatment of institutionalized chronic mental patients has been mood-altering or psychoactive drugs and chemotherapy, which reduces their level of responsiveness. "The treatment ultimately tends to be a very toxic thing," he avers. "It



Opposite page: Trainees engage in Center activities, top to bottom, macrame, typing, carpentry, crocheting. Left: Counselors meet for evaluation discussion

doesn't help their coping skills; it just keeps them under control."

Then, suddenly, they are thrust into the mainstream of society—and it just doesn't work.

"We use the term 're-socialization,' " says Myers. "It's a very broad undertaking that aims at getting the trainees to meet the community standards of behavior and communication, while building their self-esteem and self-confidence."

Not surprisingly, it is much easier to work with clients who have suffered short-term acute, severely disturbed episodes. Often the results are very dramatic. They arrive withdrawn, odd in their behavior, odd in their speech, afraid of people. But they often quickly adapt and become much more outgoing, relaxed, and sociable.

The reason, says Myers, is simple. Compared with those who have spent most of their lives in institutions and have had very little education, social skills development, or emotional development, the acute cases have spent most of their lives in the community, before succumbing to a breakdown or a psychotic episode. They have moved a lot farther along in social growth, are better educated, verbally advanced—and they tend to respond to the Center's program. Sometimes, rehabilitation for those with acute disorders can be accomplished in just three months.

"At first the common elements of difficulty are an inability to get along with people and a lack of self-esteem," says Myers. "Those trainees who come to us from Longview [a state mental hospital situated in Cincinnati] are usually withdrawn and have a tendency to distrust everyone. These are not biological problems we are talking about. They are social and psychological. We have to help them develop a sense of trust; they must be made to feel that they don't have to hide from anyone; they must be given a feeling of acceptance; we must build up their self-esteem; we must make them feel a part of something, because, basically, these people are loners. We move them toward the development of social, educational, and vocational skills."

These de-institutionalized clients are often not intellectually on par with the people they are being trained to live among. This is commonly caused by the impact of poverty and broken homes—the same forces that caused the emotional dysfunction. They can't conceptualize. They are not capable of introspection. That's why, at the Center, activities are substituted for discussion. Nevertheless, individual counseling is used for support, crisis intervention, program planning, and guidance. Traditional forms of psychotherapy call for introspection and conceptualization, but the Center trainees cannot respond to that, and the Center uses group dynamics, activities, and interaction instead.

"When a trainee is referred to us," says Myers, "we evaluate him or her by interview and by observation in various activities. In this way, we get a rough idea of the nature of the disorder, the level of intellectual functioning, motivation for change, and development of social competence. These are learned things.

"For a start, we select a range of activities that we think they may be able to handle—first, in a relaxed

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Left: Group discussions are an important aspect of rehabilitation therapy. Opposite page: More activities include, left to right, printing, jigsaw puzzles, ceramics, cooking

Continued from page 7

orientation group, then in an activity that is of interest to them, and at the same time is related as much as possible to community activities, such as woodworking, ceramics, cooking. And we offer them group activities under the supervision of group leaders. Primarily, we aim through activities and group dynamics to help them make social and behavioral changes while developing self-esteem and self-confidence.

"We operate on the premise that their problems are not primarily biological or medical, but are social and cultural. And we're trying to prepare them to adapt to the community. That's all. We're not trying to teach them a trade or educate them, except incidentally. That's not our function."

Another thing that isn't the Center's function, although Myers wishes it was, is housing the trainees. "I wish we could do that," he says. "But we don't have the space, the money, or the staff to accommodate a resident program."

This makes it particularly difficult for those coming out of institutions like Longview, many of whom have nowhere to live. But there are some programs being developed, says Myers. "Some of our graduates have set up a series of 'halfway houses.' " For example, with offices in Cincinnati's Friar's Club, "Restoration Incorporated" runs two halfway houses and also endeavors to find apartments for the trainees who have some form of income to help with the rent. Mental health centers also provide some living arrangements.

Foster homes would be an added help, but they are difficult to develop.

"We try to find tolerant families," says Myers. "Families that could provide support and companionship. But the people we work with are difficult to get along with. They are unpredictable and don't easily stay with things. It's difficult to find families who will accept this."

At the same time, a number of trainees find security and friendship at the Center and often want to stay.

"But we can only take about seventy trainees," says Myers. "And it isn't good for them to form too much of an attachment to the Center. Our treatment involves minimizing their fixations; our very program is designed to build self-confidence, to help them learn to cope, to tolerate, to control frustration, and even to accept failure."

There is no single approach that can move the trainees ahead. It has to be multidimensional. They have been institutionalized during the years essential to their societal, educational, and cultural growth. They've missed out on all of it. Their deficits make them unresponsive to traditional psychotherapy, while chemotherapy is restrictive, and at best palliative, not growth-inducing.

It is because of the trainees' social deficiencies that the Center concentrates on getting them to mix and relate constructively with each other, with their group leaders, and with the counselors. Hence, the emphasis on group activities and role models and a shaping process supported by individual counseling. It encourages trainees to believe in themselves and to believe that they have ability. Gradually expectations are set that demand more and more from the individual, that bring him or her into closer contact with others and with the community; that carry increasing responsibility, in order to infuse the very traits that became crushed in institutions.

"There is some evidence," says Myers, "that the mental hospital is not needed for a lot of people who are put into those institutions." Ultimately treatment must be in the community and must revolve around adaptation to the community.

The Rehabilitation Center was founded in 1969 by Myers, his wife,

Dr. M.H. Myers, Assistant Professor of Rehabilitation Counseling, and rehabilitation counseling students.

"I was first challenged," Myers recalls, "when I was working for the Commissioner of Mental Health in Massachusetts. I remember the Assistant Commissioner saying that we had programs for almost everyone except the chronic, institutionalized mental patient. I think that was the catalyst that brought me to set up this Center, to show that something could be done.

"The results are promising. Now, there are a growing number of programs like ours in major cities—psychosocial rehabilitation programs. It's a growing movement of recognition that medicine is not always the answer. Our graduates are steadily moving into this new field."

Recognition of Myers's work in the academic world came tangibly in October, 1978, when U.C.'s Rehabilitation Counselor Training Program of the College of Community Services was granted a five-year accreditation by the Council on Rehabilitation Education. A five-year accreditation is considered long. This was followed in January, 1979, with a three-year accreditation for the Rehabilitation Center by the National Commission on the Accreditation of Rehabilitation Facilities. Three years' accreditation is the maximum time allowed for such a facility, and it was granted for "the program's outstanding achievements in improving the quality of life for handicapped and disabled individuals." In 1980, the Center was the first facility in Ohio's Hamilton County to be certified as a mental health facility by the Ohio Department of Mental Health.

"I would like to extend this work," says Myers, looking ahead. "In terms of working with new populations, it should be extended to tie in with medical services at, say, our University Hospital. This non-medical rehabilitation arm of the University should work hand in hand with the medical rehabilitation arm. And there's also a considerable potential for innovative research programs to develop new services, new training, and special education."

Myers looks for the Center to have a growing impact on both the University and the community.