Wayne Fenton and Recovery

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We come to the recovery concept from 2 different directions. F.F. is a consumer professional who has both a scientific appreciation for schizophrenia as an illness and personal experience of battling both the illness and stigma from mental health professionals and the community. He came to the recovery concept as a function of his personal struggles and growth. A.S.B. is a behavior therapist who has long believed that social learning principles and procedures could help people with serious mental illness learn skills and strategies that would help them achieve their personal goals. While his approach and clinical values have always been consistent with recovery-oriented care, it was only recently that he had become attuned to the recovery model per se. While neither of us ever spoke with Wayne directly about recovery, our sense is that he did not need to come to it, in the sense that either of us did. He was a natural born humanist for whom the concept and practice fit like a silk glove. He could effortlessly reach outside himself and the constraints and prejudices promoted by his training to listen to clients in their terms and let them lead him rather than vice versa. That is a special talent and gift that is especially noteworthy given the traditional psychiatric training he received.

Several anecdotes supplied by former staff and colleagues of Wayne are particularly illustrative. At Wayne’s funeral service, Bob Heinssen, PhD, related a story about how he first met Wayne at Chestnut Lodge. Wayne was wrestling a rug out of his office and left the building. When he returned some time later and Bob asked what he was doing Wayne causally replied that a young man he was treating needed a rug for his new apartment, so he brought it over for him. Pat Schwieterman, Wayne’s former assistant/research administrator, described how he and a young girl he was treating would pass notes under the door of her room when she was having great difficulty establishing a trusting relationship. Pat also indicated how he would often address clients by what they did—artist, lawyer—not by name or diagnosis. When she would ask him if they worked at that job now, he generally replied not now but before and soon. The stories about the young man and the young girl stand in stark contrast to the arms length relationships maintained by most mental health professionals then and now and reflect Wayne’s commitment to helping his clients on their terms and in ways they wanted or needed to be helped. Referring to clients by their occupation is an almost prototypical reflection of 2 key aspects of the recovery model: (a) hope, the belief that things can change and (b) respect, the belief that a person is more than his or her illness. Wayne’s viewpoint and behavior stood in stark contrast to those of many (most?) mental health professionals, who think about their clients in terms of diagnosis, which invariably implies limitations and is a manifestation of professional stigma.

Neither of us knew Wayne very well during his Chestnut Lodge years, but we both became friends of his after he moved to the National Institute of Mental Health (NIMH). To the great good fortune of the field, his perspectives and values were leveraged at NIMH and had an impact on the broader field, and by extension, many more consumers than he could personally reach at the Lodge or in his private practice. Wayne and Ellen Stover, PhD, became a remarkable team during his years at NIMH. Together they developed MATRICS, TURNS, and a number of other seminal initiatives.

Most recently, A.S.B. collaborated with them on a project to jump start work in the field on assessment of functional outcomes in people with serious mental illness. Wayne knew that there is a dearth of reliable, valid, and portable measures of real-world outcomes for use in clinical trials. We are very good at measuring symptoms and functioning in the laboratory and clinic, but we do not have useful techniques for measuring community outcomes and we have little idea about the extent to which laboratory- and clinic-based assessments reflect functioning in the community: the ability to work or engage in productive activity, to have good social relationships, to pursue good health care, and to maintain a satisfactory quality of life. The literature is replete with beautifully crafted efficacy studies, but we know previously little about how to help people improve their...
Wayne understood that community functioning is our ultimate goal and a centerpiece of recovery. He also understood that a major roadblock was not therapeutic creativity but absence of an effective way to measure behavior in the community. As with MATRICS and TURNS, Wayne identified this as a major gap in our capacity to develop and test new interventions. Moreover, as with MATRICS and TURNS, he was not content to let the field develop ad hoc, in fits and starts. Rather, he realized that NIMH could really be an engine of change, so he convened an expert conference to develop recommendations and prepare a white paper that could serve as a stimulus for the field and a guide for NIMH, in the same way that he created MATRICS and TURNS to motivate industry and foster industry-academic partnerships to develop new medications to improve cognition.1

Neither MATRICS, TURNS, nor the functional assessment project specifically addressed recovery, but as with most of Wayne’s interests and initiatives, they surely enhance the recovery agenda. In discussing the future of mental health care in the United States, the President’s New Freedom Commission Report on Mental Health stated “care must focus on increasing consumers’ ability to successfully cope with life’s challenges, on facilitating recovery, and on building resilience, not just on managing symptoms.” The emphasis of all 3 of Wayne’s initiatives is precisely that: on increasing our ability to enhance functioning and make it more likely that we can help persons with serious mental illness deal with everyday problems and achieve their goals and aspirations. Wayne knew that dealing with serious mental illness means moving beyond illness, and establishing or reestablishing a self-image or persona in which mental illness is a minor component; a problem to be managed, not an overriding determinant of who the person is and what they can do. That perspective was reflected in his clinical work as well as his conceptual and managerial work at NIMH. Tragically, it was reflected in the circumstances of his death when he was apparently negotiating with a young man about the relative value of taking medication, rather than having him committed for being nonadherent.

We will miss Wayne as a friend; the field will miss him as a stimulus for creativity and a force for practical benefits for clients, and the community of consumers; and family members will miss him as a both as a personal clinician and as someone who could move the field in their direction.

Reference