

## Robert Liberman, M.D., '60: Agent of change

By Jennifer Durgin

I feel as though I've fallen into a deep, black hole and can't climb out," Dr. Robert Liberman told his psychiatrist over the phone upon landing at Los Angeles International Airport. It was April of 1995, and Liberman had just returned from a three-week lecture tour in Europe. For three months, he'd been fighting the most severe bout of depression he'd ever experienced. "I'm not suicidal," he said to his doctor. "I'm just feeling depleted and can't go on like this. We need to figure out what to do."

Liberman—himself a psychiatrist—had tried various medications to treat his depression but nothing had worked. So his doctor suggested a couple of possibilities: try some new medication combinations or consider undergoing electroconvulsive therapy (ECT, also known as shock treatment). Liberman's doctor was a member of a research center based at the University of California at Los Angeles (UCLA) that Liberman had founded and directed for 24 years. So he and his psychiatrist were coworkers, too, not just doctor and patient.

They had both noticed that Liberman often experienced periods during which he'd be highly productive. Just prior to the onset of this depression, Liberman had led an interdisciplinary team of 23 scientist-practitioners in submitting a \$2-million grant application to the National Institute of Mental Health (NIMH). The grant would provide five more years of funding for Liberman's Clinical Research Center for Schizophrenia and Psychiatric Rehabilitation at UCLA. Liberman's psychiatrist noted that he had been "sending out memos to everybody like mad" and that he was working like a "whirlwind" during the run-up to completing the grant application.

The two concluded that Liberman had bipolar II disorder, which is characterized by at least one hypomanic episode and one or more depressive episodes. "If you have a feverish period of activity, even though it may be very normal and adaptive," says Liberman, and you have bipolar II disorder, "you then fall prey to slipping down into a depression." That's what had happened upon his return from Europe.

Depression and other mood disorders are "equal-opportunity" illnesses that afflict upwards of 20% of people at some point during their

**Grew up:** Newark, N.J.

**Education:** Dartmouth College '59 (A.B. in sociology, summa cum laude); Dartmouth Medical School '60 (bachelor's of medical science, with honors); University of California at San Francisco '61 (M.S. in pharmacology); Johns Hopkins University School of Medicine '63 (M.D.)

**Training:** Bronx Municipal Hospital (medicine); Harvard-Massachusetts Mental Health Center (psychiatry); Harvard Medical School (research fellowship in social psychiatry)

**Family:** Wife Janet (they were married in 1973), five children, and four grandchildren

**Activism:** Cofounder of Physicians for Social Responsibility during the Vietnam War; author of an October 2006 letter to the editor of *Psychiatric News* decrying the involvement of psychiatrists in the interrogation of prisoners at Guantanamo

**"Then I realized," Liberman says, "that . . . I was contributing to the stigma of mental illness."**

lifetime, regardless of education or occupation. Liberman may be a Distinguished Professor of Psychiatry at UCLA and hold over \$30 million in research grants, but that doesn't exempt him. He has suffered recurrent depressions since adolescence.

When his psychiatrist presented him with the two treatment options in April of 1995, Liberman found the choice an easy one. He was tired of trying different medications, and he knew that ECT had been shown to be highly effective with only a few, transient side effects. After five rounds of ECT, Liberman felt like himself again, but he continued for a total of 12—the recommended number for serious depression. Even in the midst of the ECT treatments,

Liberman led the six laboratory chiefs at his research center through a successful site visit by the NIMH, an important step in the grant renewal process. Since then, he has been able to stay well by taking an antidepressant and a mood stabilizer every day.

It's unusual for a doctor, especially a psychiatrist, to be so open about taking psychotropic medications for a major mental disorder. In a 2006 survey of psychiatric residents, 87% (113 out of a total of 130) responded that receiving psychotherapy held little or no stigma for them, but only 34% (44 out of the 130) felt that taking psychotropic medications, such as antidepressants, held little or no stigma. While undergoing psychotherapy is viewed as a professionally relevant learning experience for psychiatrists, Liberman explains, taking medication is still seen as being indicative of a "brain disorder" that diminishes the abilities of its users.

For many years, Liberman didn't talk about his mental illness, or the medication he took, with his colleagues, trainees, or patients. "Then I realized," he says, "that by remaining in the closet about it, I was contributing to the stigma of mental illness." If psychiatrists are ashamed of having to take medication to recover from a serious psychiatric disorder, "how can the stigma ever change?" he asks. He now doesn't disclose his mental-health struggles "willy-nilly," he says, but uses his experience in a "discretionary way, to educate fellow professionals and the lay public and to motivate patients."

For example, during the 14 years that Liberman was chief of reha-

Jennifer Durgin is the associate editor of DARTMOUTH MEDICINE magazine.

bilitation medicine at the Veterans Affairs hospital in Los Angeles, he would facilitate group psycho-educational sessions in which patients with various addictions and chronic psychotic disorders would learn illness- and medication-self-management skills. Many of the patients were reluctant to take medication, in part because of the stigma.

So Liberman would ask the group, “Do you think I’m normal?” And then he’d tell them that he takes medication every day. “They were impressed that a very functional person—who they looked up to and respected—was taking medication,” he recalls, “which gave them the impetus to adhere to their regimens, with the prospects for recovery.”

Liberman, however, does not think that medication is a silver bullet for mental illness. In fact, he’s spent much of his career developing, researching, validating, and disseminating evidence-based behavioral therapies to help people with severe mental illnesses function in everyday life. Early in his career, when he was a neuropharmacology graduate student, he recognized the limitations of medication alone for persons with serious mental disorders and published an article on this topic in the *Archives of General Psychiatry*.

A few years later, when he was a psychiatry resident treating people with schizophrenia at Harvard’s Massachusetts Mental Health Center in Boston, he saw firsthand the shortcomings of both antipsychotic medications and psychodynamic therapy—which focuses on one’s past experiences and how those experiences may influence one’s behavior. He found that even when patients’ symptoms were reduced by medication, the patients remained disabled, unable to live independently and pursue a productive life.

“Under direction from my psychoanalytic supervisors, I would do my very best to find out where my patients ‘hurt’ and to give them some verbal insight,” Liberman told *Ability Magazine* several years ago. “My supervisors would finally say, ‘This patient really isn’t suitable for psychodynamic or insight-oriented therapy. . . . Just turn them over to the social workers; they’ll make sure they have a roof over their heads and three squares a day.’”

But Liberman felt it was unethical to simply give up on patients. So he began researching and developing behavioral therapies to teach people with severe mental illnesses skills such as managing their own medication regimens and finances; recognizing the early signs of relapse; establishing satisfying relationships with friends and family



MATTHEW BRINAZ

**DMS alumnus Robert Liberman has pioneered a number of psychosocial innovations, such as involving the families of people with serious mental illnesses in their therapy.**

members; and finding and enjoying recreational activities.

“People with severe mental illness who need to function in society—as opposed to being left in barren institutions—have to acquire a lot of skills and learn to advocate for additional supports and services,” Liberman told *Ability*. “Medication in no way can generate those kinds of skills. Achieving this level of competency requires a partnership between patients and professionals with a hefty input from the families.”

Treating a person with a serious mental disability without involving family members is “like having one hand tied behind my

back,” says Liberman. For the past 40 years, first in Boston and later in California, Liberman and his colleagues have designed and empirically validated behavioral family therapies to teach communication and problem-solving skills to families and their ill relatives.

**B**ehavioral family therapies and social skills training have now been adapted for use by a wide variety of clinicians working with a broad spectrum of mentally ill patients. Liberman and his team at the UCLA Clinical Research Center crafted a series of educational modules known as the UCLA Social and Independent Living Skills Program. These modules have been translated into 23 languages and are now used in more than 30 countries. Today they’re produced and sold by Psychiatric Rehabilitation Consultants, a nonprofit organization founded by Liberman.

Even after four decades of clinical practice and research, Liberman is still contributing to the field by researching new modes of rehabilitation, documenting that patients with schizophrenia can recover from their disorders, teaching and mentoring the next generation of clinicians, and continuing to see patients. He has more than 350 publications to his name, as well as 11 books, including, most recently, *Recovery from Disability*, a manual for clinicians that describes the principles and practices of psychiatric rehabilitation—a field that he is largely responsible for developing.

Liberman admits that he still works up to 60 hours a week, but he says he’s not as “feverishly involved” as he once was. “That’s better for me,” he says, “because I’m more deliberate and more thoughtful—not trying to do too many things all at once.” But of course there are psychiatric patients all over who are very glad indeed that he has done as many things as he has during his rich and productive career. ■