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THE PRIVATE HOSPITAL

American Handbook of Psychiatry

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The Private Hospital

> Choose your apothecary and I will prescribe. [The next day,] they blooded him largely, confined him to a dark room and put a strong blister in each of his arms with another all over his head. But he still was as ‘mad’ as before, praying or singing, or giving thanks continually; of which having labored to cure him for six weeks in vain, though he was now so weak he could not stand alone, his mother dismissed the apothecary and let him be ‘beside’ himself in peace, [p. 423]

James Monroe (1740), physician to the Bethlehem Hospital,

as quoted by Hunter and Macalpine (1963)

History

During the seventeenth and eighteenth | centuries, the American colonies shared with Europe a poverty of understanding and a systematic neglect of the insane. Both professional and lay people conceived of mental illness as beyond man’s comprehension and a manifestation of the spiritual world, within the province of theology. A "mad person" was believed to be possessed by the devil and represented a threat to society. If confession and penitence were unavailing, the only recourse was imprisonment or execution (Deutsch, 1949; Zilboorg, 1941). The few physicians who attempted to treat the insane invoked Cullen’s prevailing humoral theory of disease, prescribing the most stringent and inhumane treatments (Rush, 1790).

During this period, the American people lived in rural colonies and

mental illness was as scattered as the population. Families had to assume the responsibility for their own mentally ill members, and, when the care of the insane did fall on the community, the afflicted were placed with paupers in almshouses or with criminals in jails. On occasion, they were auctioned off for a small fee to work as farm laborers or "sent away," secretly taken by night to a distant village and left there, thus passing the responsibility on to another community. For the few who were treated, if that term may be used, the treatment was usually limited to confinement with chains and fetters, purges, cathartics, and blood-letting (Hurd, 1916; Shryok, 1944).

This was the pitiable condition of the insane in America before the nineteenth century. Then, in a period of one hundred years, society's relationship to the mentally ill was transformed. Reason and scientific inquiry replaced demonology and witchcraft; secular concern replaced theological condemnation, and new theories of mental illness followed the medical discoveries of the age. For example, Benjamin Rush, a Philadelphian, and the foremost physician of his era in America, devised an elaborate system of medical psychology based on William Harvey's discovery of the circulation of the blood. While his speculations proved insubstantial, mental illness was placed irrevocably in the field of medical concern (Rush, 1812; Tuke, 1885).

The eighteenth century witnessed the rise of cities in America and this concentration of population led to the formation of various learned groups,

among them medical societies, important supporters of our early asylums. The sick and infirm, and the poor became visible in the growing cities, and communities began to construct facilities, including hospitals, to care for them. To these developments in American society must be added more specific agents for change. Pinel's dramatic and well-publicized work was closely followed in America and his Traité Mèdico-Philosophique sur l'Aliénation Mentale ou la Manie, had a profound influence (1801). His concept of "moral treatment" was equally persuasive to the English Quakers and, stimulated by William Tuke, they established the Retreat near York, the most advanced institution for the mentally ill in the English-speaking world, where "the superior efficacy of a mild system of treatment was demonstrated beyond all contradiction," (as quoted by his son Samuel, 1964).

Philadelphia, with a population of more than 50,000 was the sophisticated leader of American cities. Its citizens were in close touch with European men of science and the social changes of that turbulent period. At the newly founded Pennsylvania Hospital, the first in the American colonies, Benjamin Rush had sought to establish a free-standing institution for the insane and his efforts eventually led to the move of all mentally ill patients from their basement quarters to the West Wing constructed in 1796 (Binger, 1966). Paralleling this move in Philadelphia, Governors at the New York Hospital began similar efforts to move the insane into quarters of their own. Aided by the legislature, a separate greystone building, initially housing 107

patients, was erected and opened in 1808, and the attending physician, Archibald Bruce, was required to visit it three times weekly (Hurd, 1916).

The difficulties in managing the mentally ill, which beset the newly established general hospitals, were not lost on community leaders. The Quaker community in Philadelphia observed the problems at the Pennsylvania Hospital and one of its most prominent laymen, Thomas Scattergood, visited the Retreat near York. In 1813, Samuel Tuke published Description of the Retreat Near York, and a shortened version was circulated through the Philadelphia community (Account of the Rise and Progress of the Asylum, 1814). The response was enthusiastic enough to support the construction in 1817 of the Friends Asylum at Frankford, Pennsylvania, the first private mental hospital in America (Account of the Rise and Progress of the Asylum, 1814). At this point, other American physicians and laymen moved decisively to establish institutions for the mentally ill, and between 1795 and 1825 nine hospitals were erected, seven of these under private auspices.

The Quaker influence was also felt in New York. The Lunatic Asylum of the New York Hospital came under pressure to provide a more humane environment for its increasing number of patients (New York Hospital, 1821). Thomas Eddy, President of the New York Hospital, a Quaker and well-known social reformer, acquainted with Samuel Tuke's publications, urged the

construction of a separate institution for the insane.-1 His enlightened program called for the routine keeping of case histories, a departure from the prevailing custodial philosophy. After four years of construction, the Bloomingdale Asylum was opened in 1821, a freestanding institution and a department of the New York Hospital containing space for 100 patients (Hurd, 1916).

In Boston, a similar development took place after the establishment of the Massachusetts General Hospital in 1811. The State Charter called for two departments, one for general disease and one for the insane. After a fundraising campaign, the institution for the insane was constructed, across the Charles River from Boston, and opened in 1818 under the direction of Angus Wyman, the first physician superintendent appointed in this country (Sullivan, 1819). He was particularly concerned about the nursing care and specified that the attendants should possess "amiable dispositions and soundness and maturity of judgment" (Massachusetts General Hospital, 1816, 1822). A small institution housing less than fifty patients in its early years, the asylum received a generous donation from John McLean in 1821, and was later named after its benefactor."

Baltimore followed the same course, erecting a general hospital in 1798, "for the Relief of Indigent Sick Persons and for the Reception and Care of Lunatics." Under both public and private auspices, it was finally chartered

exclusively as a mental hospital in 1839 (Hurd, 1916).

The York Retreat became the model for another early American hospital, the Hartford Retreat. Sponsored by the newly formed Connecticut State Medical Society in 1821, the General Assembly was petitioned by Thomas Hubbard to provide an asylum or retreat for the more than 1000 insane persons in the state to "mitigate their suffering and restore their reason" (An Act of Incorporation, 1822). Following Pinel and Tuke, medical records were required and an attending committee was appointed to review the medical and moral practice of the institution and to report abuses. It was chartered in 1822 and opened in 1824 under Eli Todd, a prominent Connecticut physician whose interest in mental illness was spurred by the recurrent depressions and eventual suicide of his sister (Braceland, 1972).

The description of early private hospitals would not be complete without noting further developments at the Pennsylvania Hospital. Though the West Wing was a decided improvement, Rush later advocated the erection of entirely separate buildings for the insane but, at his death in 1813, Philadelphia had no physician who supported this view. Cholera epidemics preempted other medical interests until the 1830s when the numbers of mentally ill from Philadelphia's expanding population prompted the Board of Managers to secure 110 acres outside the city and construct a new hospital which received its first patients January 9, 1841, under the direction of a

Quaker, Thomas Kirkbride (Bond, 1947)9

Other private hospitals established before the mid-nineteenth century included the Hudson Lunatic Asylum (1830), Brattleboro Retreat (1836), the Mount Hope Retreat (1840), and the Butler Hospital (1847).441 These institutions, because of their small size, could provide individualized care and flexible treatment programs. They played a central role in the development of American psychiatry, their medical superintendents forming the nucleus of the Association of Medical Superintendents, founded in 1844, forerunner of the American Psychiatric Association (Overholser, 1944).

Nineteenth-Century Private Hospital Treatment

> A maniac had made several attempts to set fire to the hospital; upon being remonstrated he said, 'I am a salamander;' 'But recollect,' said my friend Coates, 'all the patients in the house are not salamanders.' 'That is true,' said the maniac, and never afterwards attempted to set fire to the hospital.

Reported by Thomas Eddy of his friend Samuel Coates,
President of the Pennsylvania Hospital (1815)

Treatment between 1800 and 1850 was profoundly influenced by Pinel's writings, by Tuke and the York Retreat, and by John Conolly, the English advocate of non-restraint (1916). The Quaker community was a vehicle for bringing this treatment philosophy to the United States and it found a ready acceptance in the newly constructed "Retreats," freed from

their parent hospital practices and with no traditions to uphold.

The death of Benjamin Rush in 1813 signaled a turning away from the medical therapies which he advocated to "moral" treatment, which arose from a humanistic and psychological interpretation of mental disorder. Purges, emetics, Rush's mechanical contrivances, the "gyrator" and the "tranquilizers," and the induction of fear, gave way to less violent medications, such as the opium derivatives, stramonium, quinine, iron tonics, and continuous baths (American Journal of Insanity, 1846; Ranney, 1862). Punishment, confinement, and shackles and chains were replaced by policies of non-restraint. Moral treatment returned humanity and reason to the insane. In the words of the Governors of the New York Hospital on the opening of the Bloomingdale Asylum, "This institution has been established with the express design to carry into effect that system of management of the insane, happily termed moral management, the superior efficacy of which has been demonstrated in several of the hospitals of Europe, and especially that admired establishment of the Society of Friends, called The Retreat, near York, in England" (New York Hospital, 1821).

The Committee of the Connecticut State Medical Society planning the Hartford Retreat recommended: "Such an asylum should be the reverse of everything that enters into our conceptions of a madhouse. It should not be a jail, in which for individual and public security the unfortunate maniacs are

confined. Nor should it merely be a hospital where they may have the benefits of medical treatment— for without moral management the most judicious course of medical management is rarely successful. . . ." as quoted by Braceland (1972).

Wyman, in his report to the board of governors of the Massachusetts General Hospital in 1822, sounded a similar note, writing: "Living under a system of rules and regulations for everything has a powerful effect in tranquilizing the mind, breaking up wrong associations of thinking and inducing correct habits of thinking as well as acting; and finally . . . lunatics are not insensible to kind treatment, that whips and chains are forever banished from every well-regulated asylum for the insane and that kindness and humanity have succeeded to severity and cruelty." It was best stated by Amariah Brigham in 1847, shortly after leaving his post at the Hartford Retreat: "The removal of the insane from home and former associations, with respectful and kind treatment under all circumstances, and in most cases manual labor, attendance at religious worship on Sunday, the establishment of regular habits and of self control, diversion of the mind from morbid trains of thought are now generally considered as essential in the moral treatment of the insane."

At mid-century, Thomas Kirkbride, by then the foremost institutional psychiatrist in America, developed a plan for the organization and

construction of mental hospitals that was successful at the Pennsylvania Hospital and served as a model for thirty-one states during the next half-century. At a time when there were no standards of privacy, comfort or safety, the Kirkbride Plan was an enlightened and humane advance in the care of the mentally ill (1880). A colleague of Kirkbride's in his later years and superintendent of the Butler Hospital in Providence, R.I., for two decades, Isaac Ray, became a national authority on legal aspects of mental disorder. In a volume published in 1863, Ray examined the principles of mental hygiene defined as "the art of preserving the health of the mind against all the incidents and influences calculated to deteriorate its qualities, impair its energies or derange its movements." Another hospital superintendent, George Cook of Brigham Hall, had published the first two papers on mental hygiene in 1859. These principles were later put into practice in the earliest outpatient psychiatric clinic in America established at the Pennsylvania Hospital by John Chapin in 1885.

The study of treatment results first appeared in annual hospital reports, many of which exaggerated their successes. The founding of the *American Journal of Insanity* in 1844 encouraged more dispassionate research in mental hospitals, particularly concerning the natural history of the mental disorders (Cowles, 1858). Pliny Earle of the Bloomingdale Asylum, brought new vigor into the evaluation of treatment in his studies over a twenty-year period (1887). In 1882, Edward Cowles established at McLean Hospital in Waverley,

Mass., the first permanent training school for nurses and took the then daring step of introducing women nurses to male wards, against widespread condemnation (Cowles, 1895; Tuke, 1885). By the end of the century, occupational therapy, which had long been a mainstay of moral treatment, was dignified by a formulation of its principles and practices, opening a new career choice in mental health largely through the efforts of William Rush Dunton at the recently opened Sheppard and Enoch Pratt Hospital (Forbush, 1971) in Towson, Md.

Psychodynamic Theory and the Private Hospital

> For a considerable time I have harbored a suspicion that paranoia, too—or classes of cases which fall under the heading of paranoia, is a psychosis of defense; that is to say, like hysteria and obsessions, it proceeds directly from the repression of distressing memories and that its symptoms are determined in their form hy the content of what has been repressed (1955, p. 174).

Sigmund Freud (1896),

"Further Remarks on the Neuro-Psychosis of Defense"

Although Freud did not concern himself with hospitalized patients or form a completed theory of the psychoses, he established through his case histories and theoretical papers the central importance of the genetic and unconscious determinants of the major psychiatric disorders (1855; 1957; Pao, 1973). Subsequent workers, most notably Harry Stack Sullivan,

formulated further psychodynamic concepts which applied directly to the treatment of the hospitalized patient (1940; 1962). The development of ego psychology with its many contributors, added to the understanding of these disorders and defined the psychodynamics of the treatment process.

The impact of these theories on the conduct of private hospitals was substantial. Psychodynamic considerations became a part of every hospital's diagnostic assessment and treatment program. The psychology of human development and behavior became a basic element in hospital curriculums for medical and nonmedical staff. The functioning of groups in the hospital setting and the importance of group process to the outcome of treatment became evident to hospital clinicians and treatment in groups became standard practice. Administrative procedures and the organizational structures of many private hospitals reflected the advances in knowledge of the dynamics of human interactions. Sociologists, social psychologists, and social anthropologists now consider the hospital itself as a social entity from which much can be learned about human interactions.

Modern Private Psychiatric Hospitals

> It is hard to keep in mind what it means subjectively to be a mental patient; to be so fearful that each aspect of the environment represents a threat to one's existence; to experience the world as unreal and to see the 'outside' as just a flimsy structure with no substance; to live with a feeling of restraint and being closed in, or suffocated, and to feel rebellion and resentment at this and be unable to express it in any effective way; to

> experience utter, desperate, and unrelieved loneliness, with no hope of change; to feel that in the entire universe there is no person that will ever understand one; to believe that one's actions have no effect and that one is not affected by the actions of others (1954, p. 68).
>
> A. Stanton and M. S. Schwartz (1954),
> The Mental Hospital

Developments in the past seventy years have radically altered private psychiatric hospitals and their role in the treatment of the mentally ill. Today, diversity is their most notable characteristic and they range from small and specialized hospitals to comprehensive mental-health facilities that meet the entire mental-health needs of a defined geographical or population area. Some private hospitals have little or no relationship to governmental facilities; others are closely affiliated with governmental institutions. Some private hospitals are one part of a larger body containing both governmental and nongovernmental components; others carry out mental-health services by grant or contract arrangements with states or municipalities. Still others have major commitments to teaching and research. A private hospital distinguishes itself from other types of hospitals by placing its highest priority on the excellence of patient care. Though it may engage in many other activities including teaching, research, and mental-health related social programs, its first responsibility is to the individual, mentally ill person who seeks its help.

Two criteria define the character of the private hospital; the scope of its services and the population it serves. The range of services reflects the many and diverse needs of patients suffering from mental illness. In the nineteenth century, hospital treatment was largely confined to inpatient care. The past seventy years has seen a gradual expansion of services. At the present time, the range of service is extensive and the hospital has become a locus or starting point for these varied programs. The decision to place a patient in the hospital or in any other treatment program rests on the nature of the disorder and its symptomatic expression. Inpatient care, while remaining a vital concern and activity of most hospitals, is no longer the sole method of treatment and is but one of a number of treatment programs which a hospital may offer. The increase in hospital services has allowed a more exact fit between the needs generated by the patient’s illness and the specific treatment plan.

A partial listing of services includes:

psychiatric diagnostic evaluation

individual psychotherapy

group psychotherapy

family therapy

social casework

milieu therapy

psychiatric nursing care

behavioral modification therapy

activity therapy

art therapy

music therapy

recreational therapy

occupational therapy

psychological testing

educational testing

vocational testing

rehabilitation training

counselling

special educational services

drug treatment

physical therapies

medical and dental services

inpatient hospital services

day hospital services

night hospital services

outpatient services

crisis intervention

All of these elements of the treatment program share the basic emphasis on the psychiatric care of the individual patient. Services are integrated and a comprehensive range of appropriate services is available for each patient. Established patterns of responsibility set the priorities of treatment and care so that the patient’s condition is regularly reviewed and the therapy reassessed to meet the current needs of the patient and his life situation. One physician is identified as responsible for the planning and implementation of treatment and, while he may seek consultation, responsibility for the patient’s care is his and is not dispersed among the members of a group. Integrated rehabilitative services extend beyond the hospital itself and arrangements with other institutions make further services available to the patient and his family.

The size of the patient population has an important impact on the

organization of services and the delivery of quality care. Large institutions, by necessity, sacrifice the individuality of patients and personnel because their policies and procedures must be standardized, and a uniformity of approach is required.

Private hospitals have traditionally been smaller than their public hospital counterparts; ideally small enough so that each patient and staff person is a recognized member of the hospital community. As a consequence, the entire hospital embodies the therapeutic program. The flexibility of the program is a direct outgrowth of the size of the hospital and large programs cannot quickly meet the changing needs of each patient and the demands of a continually changing patient group. A small, flexible hospital program permits the fullest utilization of the principles of milieu therapy, for a hospital is not merely a place where patients are treated but a community in which the major activity is patient care.

Certain groups of patients, such as the elderly, and those with alcoholism, drug addiction or chronic psychotic disorders require specialized services. Many hospital programs and some institutions specialize in particular patient subgroups or disease categories. In addition, they take into account the age of the patient and the severity of his disorder. This requires adaptation of the therapeutic modalities to the particular patient group and direct collaboration with other facilities and organizations such as Alcoholics

Anonymous, schools, programs within the criminal justice system, rehabilitation programs, and community services for the aged.

The physical surroundings must also reflect concern about the individuality of each patient and contribute to the patient's sense of familiarity and safety. A simplified living situation should support the patient's sense of privacy and self-respect, and promote the natural interactions between the patients and staff. Overcrowding, which is detrimental to both patients and staff, must be avoided to allow the successful functioning of the therapeutic milieu.

Continuity of care forms an indispensable link between the patient and his hopes for a resolution of his illness and requires an exact knowledge of the patient, the origins of his illness and its progress, his current status and his family, and social circumstances. The dependability of the treatment program will rest on long-term experience with the treatment and the situation in which it is given. A familiarity with the patient's responses to treatment is a prerequisite for further additions to the treatment program. Changing personnel disrupt the treatment to the detriment of the patient.

The entire hospital community participates in the therapeutic endeavor. This includes not only the traditional nursing services but also the "nonclinical" departments such as dietary and housekeeping personnel who

have daily contact with patients. To the extent that the patient’s disorder permits, he engages fully in the community life of the hospital. Therapeutic patient activities include not only expressive modalities, such as occupational and recreational therapy, but also task-oriented activities, such as patient work programs or group projects. The essence of the patient’s involvement in the hospital community is the preservation and strengthening of those capacities and capabilities which have not been compromised by the patient’s disorder. The prevention of the "atrophy of disuse" is as central to the hospital program as the direct treatment of the patient’s disorder.

Skilled nursing staff are basic to a successful treatment program and the staff of the private hospital should be selected for their personal aptitudes and skills in treating mental illness. A high staff-patient ratio provides a flexible staffing pattern that maximizes attention to the particular needs of each patient. Staff members should have a full knowledge of the patient, his disorder, and his current family situation. Inservice educational programs are essential to teach the basic elements of mental disorder and the subtleties of interpersonal relationships. Only then can the staff see the patient as a troubled human being with interests, talents, and capabilities, despite the limitations imposed by his illness.

The relationship between individual staff members and patients forms an essential and integral part of the treatment program and should be

encouraged. Such relationships form the human context for the therapeutic experience of the interest of another person and the development of mutual respect. They also provide an environment for the expression of the patient's habitual modes of relating to others and allow for repeated examination of his pathological adaptations. For the modification of unconscious mental functioning, the establishment of transferential relationships is essential and infantile derivatives, thus elicited and expressed, form the matrix of the therapeutic interactions with the hospital staff. In this instance, the constant environment of the hospital program is a necessary backdrop for the expression of unconscious conflicts and their resolution.

The hospital maintains the continuity of relationship between the patient and his physician for as long as psychiatric treatment is indicated, often over a period of several years. In this respect, the psychiatrist resembles the family doctor whose knowledge and availability to the patient and his family grow more valuable and effective as time passes.

The psychotherapeutic relationship is the optimal means through which the patient brings his disturbance of adaptive functioning under rational scrutiny. Individual psychotherapy is of prime importance for the improvement of interpersonal relatedness and the alteration of the emotional factors that underlie mental disorders. Group techniques have proved essential to most hospital treatment programs. The budgetary requirements

of many public institutions require the use of group techniques as a primary modality of treatment. The private hospital has the responsibility of providing each patient with a program suited to his own needs, which includes both individual and group treatment.

Sedatives and tranquilizing medication, judiciously employed, is of substantial benefit to many patients. The availability of a range of major and minor tranquilizing and antidepressive agents has led to their use in all hospitals. The prescription of these drugs must be aimed at target symptoms and the improvement of adaptive and integrative functions enabling the patient to expand the range of his activities and participate more fully in the therapeutic and rehabilitative effort.

Medical and dental services are an essential constituent of all psychiatric hospital programs. The contributory role of nonpsychiatric medical conditions to the mental illness is established during the hospital diagnostic study and appropriate treatment instituted. For all patients under the continuing care of the hospital, medical and dental services are provided directly or through arrangement with another resource.

Hospital Treatment

All psychiatric hospitals attempt to provide comprehensive treatment for the disturbed patient while protecting him from his destructive and self-

destructive impulses. Hospital treatment should interrupt the process of isolation and destructiveness that the patient's illness has provoked in himself, his family and others, and allow the family to reestablish its integrity usually strained under the impact of the patient's disorder.

Prior to treatment, the patient and his family are advised of the need for treatment and the nature of the services the hospital offers. During hospital treatment further diagnostic study, including psychiatric evaluation and additional special studies, are carried out. Following discharge from the program, a period of follow-up contact is essential if recurrences are to be prevented.

Treatment programs must take into account that psychiatric disorder may be acute or chronic and relapsing. Hospital treatment subsequently may be categorized as short-term or long-term. The selection of the appropriate treatment program rests on the diagnosis, the factors that have contributed to the disorder and the immediate problem that confronts the patient.

Disorders which develop acutely, for example, those associated with some disruption of the life situation, that occur in response to an external trauma or the loss of a loved one, or result from a clearly defined and circumscribed intrapsychic conflict, are most suitable for short-term treatment.

Long-term treatment may be required for disorders which have an insidious onset, those having a pervasive and unrelenting downward course, those not resulting directly from a defined trauma or loss, or associated with a developmental arrest. Because it is difficult to predict the course of psychiatric disorder, most patients are treated initially within a short-term program. For those who do not respond, transfer to a long-term facility should be made. Hospital programs should clearly define the goals of their programs and whether they are short-term or long-term as the modalities of treatments differ markedly.

Short-Term Treatment

The goals of the short-term treatment program are to reestablish a successful adaptation of the patient to the world around him, especially to those people closest to him, and to help the patient regain an equilibrium between the inner and outer forces that govern his functioning, thus freeing him to further pursue his life interests. This often means helping a patient through a life crisis whose elements have been elicited and related to each other during the diagnostic study. Occasionally, the process of clarification itself during the diagnostic process is sufficient to resolve the immediate difficulty. Usually, a combination of changes must take place in the patient and treatment procedures will vary accordingly. Depending on the patient’s internal pathology, a reduction in anxiety is helpful. Often, assistance in

establishing controls over certain behaviors is necessary. The patient can be helped to consider and develop alternative pathways for action. Healthy elements of family support may be mobilized and a return to ordinary life routines is usually indicated. At times, it is necessary for the patient to remove himself from a pathological family or social situation. During the course of treatment, the patient is helped to develop his capacity for self-observation.

The variety of treatment modalities provided by hospitals has already been noted, but their application within the framework of short-term intervention reflects the special goals of this procedure.

The private hospital may offer short-term treatment in a program of brief hospitalization followed by day care. Brief hospitalization offers temporary protection of the patient from outside stress with which he cannot cope and from his own impulsiveness or destructive inclinations. The move into a day-care program, in addition to its diagnostic usefulness, offers a daily respite to the patient and an opportunity to examine his current methods of dealing with his life circumstances free from the unbearably stressful home situation. Supportive psychotherapy deals with those aspects of the patient's difficulty that are susceptible to conscious scrutiny and directly supports the patient's own autonomous problem-solving efforts. Group meetings and/ or short-term group psychotherapy emphasize current relationships and life

situations. They encourage group members to compare experiences and share their understanding and their patterns of coping. Milieu treatment for either the day treatment or hospitalized patient provides a structure of daily routine and a reliable and consistent group of professional people with whom the patient interacts.

From the outset, attention is focused on the circumscribed nature of the hospitalization and the goal of an immediate return to the home or a move to a suitable living situation. Somatic therapies, including drug treatment, are utilized with these same goals in mind.

Occupational and recreational therapies provide a structured relationship around a task or activity. These and other activities reestablish the reality of the patient’s capabilities, personal interests, and competence. Modulated expression of feelings and awareness of personal concerns may take place through the medium of music, drama, art, and dance therapy under the guidance of a person experienced in these modes of treatment.

Casework with the family is central to the treatment program and reflects the importance of the current life situation. Emphasis is placed on the family’s understanding of the patient’s immediate difficulty and the ways in which they can be supportive to his effort to deal with it. Family members are helped to restructure the home situation to better meet the needs of the

patient and of themselves.

Planning for discharge and for appropriate care after discharge from the hospital or hospital program is an important part of the treatment endeavor. All illnesses severe enough to require hospitalization also require this type of aftercare planning and patient contact, and the success or failure of short-term hospitalization will rest on this aspect of the therapeutic program. Thus, the continuation of appropriate treatment measures and the continuing assessment of the living situation ensures that outside circumstances contributing to the illness are eliminated or modified.

Long-Term Treatment

The criteria for patient selection for longterm treatment are: (1) the previous failure of short-term measures; (2) the presence of a chronic or recurring disorder; and (3) the need for a stable and therapeutic environment that will support the treatment process as long as is required.

Patients who require long-term hospital treatment have usually been hospitalized briefly without success and a variety of measures, including drug treatment, have failed to prevent the progress of the disorder. Though this situation is often desperate and their families hopeless, they are not in an acutely conflicted situation.

These patients show a gross inability to cope with normal living situations and their histories reveal arrests in psychic development and long-standing disorder. The resolution of the disorder requires a resumption of development beyond the point of arrest.

The goals of long-term treatment are to rid the patient of the disabling symptoms and behavior which result from his disorder, and to remove developmental arrests allowing further emotional growth. For the more severely disordered patient, this will require a significant alteration in the level of his personality functioning and the intervention of a skilled psychotherapist. Changes in intrapsychic processes and the modification of the personality affect the patient's view of himself, his ability to contain his impulses, his relationships to other people, and his capacity to lead a more autonomous life. Over the period of treatment, the patient should gain an understanding of the forces that contributed to his disorder so that compromised or undeveloped capabilities can be explored and utilized. Rehabilitation plays an important role in the treatment procedure and should develop the maximal use of partial functions and establish the optimal circumstance for a range of self-supporting activities.

Comprehensive long-term hospital treatment programs include motivational, psychological, interpersonal, educational, and environmental methods. All aspects of the patient's adaptation to the world, both

pathological and healthy, are incorporated in the therapeutic endeavor.

Environmental structure is basic to any longterm treatment program. A common cause for failure of short-term therapy is the failure of the patient to maintain a stable living situation. The living experience of many patients prior to hospitalization is chaotic, dangerous, and destructive to their families and themselves. Hospitalization establishes a safe, reliable, consistent environment. The daily routine of sleeping and eating, and the activities of self-care are reestablished. The expectations of the environment are unambiguous and predictable. Behaviors that are detrimental to the patient and others are limited. An essential constituent of any long-term environmental structure is the interaction between the hospital staff and patients. These interpersonal relationships and the direct experience of the patient with other human beings interested in his welfare and skilled in dealing with the distortions of human relationships imposed by the patient's illness, are powerful tools in modifying the patient's pathological adaptations. These interactions take place formally, informally, individually, and in groups. They may be concerned with a task having to do with personal hygiene or eating, or they may be spontaneous and without a task orientation. These relationships can only develop gradually as the patient gains a feeling of worth and acceptance by another person and comes to value their interest and attention. In groups, the interactions and the feelings of each of the members are identified and brought to the attention of the group. The

stability and continuity of key figures of the hospital staff are essential to the development of these individual and group relationships.

Psychological study begins with the initial psychiatric interview and the formal psychological testing procedures. The identification of the conscious and unconscious conflicts within the personality of the patient determines the nature and role of subsequent psychological investigation. Intensive individual psychotherapy, utilizing the intense relationship between the therapist and patient to study the patient’s external and intrapsychic life, is essential to help the patient become aware of the forces that shape his relationships with the world and the impediments that underlie his disability. While psychotherapeutic technique varies as widely as surgical procedures, the basic goal is the remission of symptoms and relief from paralyzing internal psychic conflict. Such basic changes in personality functioning require a relationship that with time will allow the full development of pathological patterns of behavior that then can be consciously experienced, clarified and resolved. These often hidden attitudes and beliefs that the patient holds about himself and the world are reenacted toward the therapist and the environment, often in negative and self-destructive ways. Hence, the collaboration of therapist and those responsible for the environmental structure is essential.

In addition, the therapeutic program addresses the healthy, progressive,

and nonpathological aspects of the patient's functioning. A range of planned activities is provided which reflect the wide diversity of human capacities still available to the patient. For the most severely disturbed patient, they may be limited to the basic human functions of self-care. For the less disturbed patient, a greater variety of activities may be effectively mobilized.

A partial list includes the following:

occupational,

recreational,

music,

art, and

dance therapy

exercise and sports

patient work programs

educational classes

patient government

psychodrama

Some of these activities have specified therapeutic aims and utilize

specialized techniques and materials. This may involve the production of an object or artistic creation. It may involve the recognition of feelings through rhythmic movement or musical or dramatic expression. These therapeutic procedures may be applied individually or in small groups. Other activities have a more general purpose, to expand the healthy or nonpathological functioning capacities of the patient. Exercise and team sports provide a constructive avenue for physical expression of feeling and conflicts. Supervised teamwork and competition allows an expression of aggression, and feelings of jealousy and envy within a secure and structured situation. Classes geared to the patient's capabilities and interests teach skills such as self-care, cooking, and mechanics, and enlarge the patient's awareness of his own capabilities and cultivate healthy interests hitherto dormant.

Patients who are able to work derive considerable benefit from hospital employment. For many, it is a renewal of a satisfaction which had been given up at the onset of the illness. For others, it is the first evidence that they are needed, useful and valued for what they can do. Work situations must reflect as careful an understanding of the patient's needs and capabilities as other therapeutic activities. The responsibilities of a job are an excellent indicator of the readiness for responsibilities in the community.

Rehabilitation may be considered the joining together of these activities in a planned sequence and their further elaboration in a community setting.

The rehabilitation effort goes beyond the patient, however, and includes structures within and without the hospital. These structures include administrative arrangements to continue contact with the patient as he moves toward more community responsibility and involvement, a continuing assessment of the patient’s functional capacities and limitations, and provisions for appropriate living situations, work opportunities, social activities, and sources of financial support, medical care, and psychiatric and social services. While the hospital may not provide all of these services itself, it has arrangements with other community facilities which, together, provide a coordinated and integrated program.

Hospitals vary considerably in their emphasis on particular elements of the long-term treatment program, depending on the factors which maintain the illness, the type of limitation suffered by the patient, and other characteristics of their patient population. Each hospital program aims for the maximal development of the patient’s capacities to function in society and the reduction or elimination of the disabilities arising from the patient’s disorder.

The Treatment of Children and Adolescents

While children and adolescents have been admitted to mental hospitals for more than a hundred years, the modern development of institutional programs devoted specifically to youth began with the founding of the

Juvenile Psychopathic Institute in Chicago in 1909. This was followed by the establishment of the Judge Baker Foundation in Boston in 1917 and, after World War I, the first Child Guidance Clinics in Norfolk, Va., and St. Louis, Mo., sponsored by the Common Wealth Foundation (Gardner, 1972). Since that time, many mental hospitals have established departments for children and adolescents, and in the past decade the proportion of patients admitted to the hospital under twenty-one years of age has risen dramatically.

Accumulated experience has revealed marked differences between mental disorders in children and adults, differences affecting their diagnosis and treatment. Mental illness in children not only compromises psychic structure and function but limits and distorts development. The child, still immature, remains dependent on his parents and other adult figures not only for his nourishment and protection but also for the transmission of their culture and values which the child must have to meet the responsibilities of adulthood. The child will have different needs, depending on his chronological age, and his level of maturation and development. The impact of the environment with all its psychological and social complexities is much greater in childhood and group relationships have a special significance in this period of life as the child seeks to establish a durable autonomy from his parents. The vital role of education in every child’s life cannot be overemphasized. These principles and others related to the mentally disordered child have been carefully described in the Standards for

Psychiatric Facilities for Children (American Psychiatric Association, 1971).

The consequence of these differences, between child and adult, on the care and treatment of children is substantial. The indications for hospital treatment, particularly for inpatient care, must fully take into account the patient's dependence on his family. Removal from the family may be indicated by the patient's disorder, the family disorder around the child patient, or pathological relationships between the child and his family. However, the severity of the illness must be weighed carefully to assure that the benefits of hospitalization outweigh the harmful effects of disrupting the child's life and home situation.

Psychiatric facilities for children are organized to meet the needs of children as well as to treat their psychiatric disorder. Space is an essential ingredient; both the private space allotted to each child as his own, and the open, out-of-doors space which the child can use and explore. Provision must be made for the child's safety, physical health, and for appropriate supervision. The staff who serve *in loco parentis* must be trained in child development as well as child psychopathology and be able to distinguish symptoms of illness from temporary regressions or normal age-related variations in behavior.

Therapeutic programs for children and adolescents cover the same

range of modalities as their adult counterparts with the exception of the physical therapies. Treatment is carried out within the context of the child's chronological age, maturation, and developmental level. Education forms an essential part of every therapeutic program and the educational component is designed to meet developmental needs within the limits set by the mental disorder. The provisions for peer-group and social relationships, recreational and athletic activities, special interests and appropriate job training must be included in each child's and adolescent's program. The treatment of children requires a more extensive program, a more defined and explicit treatment structure, and a larger therapeutic staff. As the child improves, the ongoing therapeutic work prepares also the family for his return home. Postdischarge treatment planning for the child and his family is essential to maintain the gains of treatment.

Education and Research

Though not primary goals of the private psychiatric hospital, significant educational and research endeavors have marked the development of private hospitals during the past century.

Education

Since Kirkbride's early lectures to his nursing attendants, education of hospital personnel has played a vital role in the patterns of patient care.

Although many colleges now offer courses in mental-health practice, the special skills required for the care of psychiatric patients must be taught through direct experience in an inservice educational program. The curriculum includes the observation of patient-staff interactions, the delineation of characteristic patterns of patient behavior, self-observation by staff of their responses to the varied types of patient behavior, the study of group processes in both patients and staff, the awareness of each patient's unique qualities, and many other topics. This type of curriculum is most meaningful in conjunction with daily contact with patients.

All members of the hospital staff are included in educational programs appropriate to their role and function. Orientation, continuing education, and training for increased responsibilities are also part of the hospital curriculum. Instruction may also be provided for a variety of professionals at both undergraduate and graduate levels. A partial list includes:

physicians

nurses

psychologists

social workers

mental health workers

teachers

counselors

occupational,

recreational,

art,

music,

dance, and

activities therapists

Affiliation with universities, medical and nursing schools is the rule, and teaching by the hospital staff may be in either the hospital or university setting.

The hospital provides a natural setting for the study of human, psychological, and social processes. Training in the recognition of symptoms of mental illness leads inevitably to the study of psychological functioning and those biological, developmental, and environmental factors that affect it. The milieu treatment program provides a natural laboratory for the study of social and group processes as well as the impact of administrative structure on patient and staff behavior. Here the student may experience at first-hand

the process of group formation, the establishment of group goals, the influence of psychopathology on group process, and the importance of group functioning to changes in patient and staff behavior. Thus, beyond the training for a specific professional task, education in the private hospital examines the complexities of man's feelings and behavior as they are experienced within himself and in relation to others.

Research

In the early nineteenth century, research in psychiatry began in psychiatric hospitals, the first opportunity for physicians to study mental illness in groups of patients in one setting. Of necessity, the early studies of Rush and others described and classified the natural history and phenomena of disease. Studies of moral treatment and its efficacy, accounts of hospital organization, construction, and management preoccupied the early superintendents, as their annual reports document. The two most important works published at this time were Benjamin Rush's *Medical Inquiries and Observations Upon the Diseases of the Mind* (1812), and Isaac Ray's A *Treatise on the Medical Jurisprudence of Insanity* (1838). The new *moral theory* of treating insanity was discussed by Amariah Brigham (*Remarks on the Influence of Mental Cultivation and Mental Excitement, upon Health,* 1832), Thomas Upham (*Outlines of Imperfect and Disordered Mental Action,* 1838), and William Sweetser (*Mental Hygiene,* 1843), as cited by Bunker (1944).

The *American Journal of Insanity,* the first periodical in English solely concerned with mental disorder, was founded in 1844 by Amariah Brigham, changing the course of psychiatric research in this country. For the next fifty years, articles, notes, and commentary were contributed by hospital superintendents and other physicians, leading to important independent works (Bunker, 1944) by Kirkbride, Earle, and Cowles, and the establishment of hospital-research laboratories (American Journal of Insanity, 1898; Hurd, 1916).

Today, research in private hospitals extends to all aspects of mental disorders and their treatment. In the area of clinical research, private hospitals are in a unique position to make contributions to our knowledge of mental illness, as the pioneering studies of Stanton and Schwartz have demonstrated (1954). The primacy of patient care leads inevitably to the examination of psychological, social, family, and group processes that contribute to or maintain illness. The evaluation of specific therapies, such as the psychotherapies, drug therapies, and milieu treatment, in their short- or longterm effectiveness, is readily accomplished in the hospital setting.

Program evaluation utilizing research methodology is an essential component of clinical investigation and measures the effectiveness of existing services. Other valuable research endeavors include outcome studies, assessment of community's needs, the comparison of alternative methods of

treating different segments of the population, and studies of administrative organization.

Biochemical, physiological, psychological, and sociological studies are carried out by a number of hospital research departments, usually affiliated with a medical school or university. Formal research programs are carried out through the support of federal and state governments, private institutions and foundations, churches, individuals, and the hospitals themselves. A variety of institutional settings conduct research in biochemical, physiological, psychological, anthropological, and sociological factors in mental disorders. More extensive research programs and those removed from clinical practice operate more effectively in a separate affiliated research institute or foundation.

Conclusions

The private hospital, a wellspring of modern psychiatry, today has a broadened role in the delivery of mental-health services in the United States. Its treatment programs have extended to children and adolescents, and include all forms of mental disorder. Its programs go far beyond in-hospital care and provide both curative and preventive services. Through affiliations, jointly sponsored endeavors, and formal ties, the private hospital fulfills a necessary role in the community health system, sponsored by both public and

private resources. Its educational and research programs are extensive and support its primary goal of excellence in patient care. From the establishment of the earliest institutions, the private hospital has remained a basic part of mental-health care in the United States.

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