Psychotherapy Guidebook

Mental Hospital as a Psychotherapeutic System

Louis Linn

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DEFINITION

The Mental Hospital is an institution for the in-patient care of the emotionally ill, maintained by private endowments, public funds, or both.

HISTORY

In medieval times, church-sponsored facilities were often models of humane concern. Too often, however, these settings became houses for the care of the indigent and the friendless, and in which treatment and nursing were so poor that few emerged alive. In the late eighteenth century the French psychiatrist Pinel removed the chains from confined psychotic patients. This proved to be a revolutionary act that triggered similar developments throughout the Western World. Dorothea Lynde Dix pioneered in the establishment of the state hospital system in this country. In her day, these were models of so-called moral treatment and of the no-restraint approach to patient care.

In the twentieth century a combination of population growth and a lack

of effective treatment methods led to mental hospital overcrowding. In time, these institutions degenerated into antitherapeutic storage depots for the unwanted. The term “asylum,” which once meant a sanctuary or a place of peace, became a term of opprobrium. In 1904, ex-patient Clifford Beers wrote A Mind That Found Itself, a manifesto that led to the formation of the National Association for Mental Health and to some beginnings of hospital reform.

TECHNIQUE

In the 1940s a series of fundamental developments occurred that altered the mental hospital situation. Effective somatic methods of treatment appeared; namely, electroshock therapy (ECT) for depression and mania and insulin therapy (ICT) for schizophrenia. In addition, contributions from group psychology led to the concept of the “hospital as a therapeutic community” and the individual ward as a “therapeutic milieu.” In the 1950s new medications appeared with unprecedented ability to control psychotic symptoms. For the first time community-based treatment of the major mental disorders became a practical possibility. In the 1960s, federal legislation implemented this breakthrough with the concept of the Comprehensive Community Mental Health Center that stated that the treatment locale of choice for most mental patients is the community in which they live, in contact with family, friends, and their customary occupational and recreational opportunities. Along with this, psychiatric units in general

hospitals became widespread.

We are now in a new phase of mental hospital utilization. It is clear that there will always be chronic, incurable patients whose numbers will increase in spite of the most optimistic therapeutic advances imaginable. These chronic patients must be cared for, some in hospitals and some in community-based sheltered settings that can provide viable alternatives to long-term in-patient care. The plight of the chronic, incurable patient remains a major problem awaiting satisfactory solution.

The acute mental disorders provide a different set of problems. The most important fact about acute psychiatric hospitalization is that it occurs when a previously satisfactory adaptional state ceases to work. For example, a schizophrenic patient may be living in the community over a period of years, a potentially suicidal patient may contain his self-destructiveness, a sexual exhibitionist may control the urge to act out his exhibitionistic desire. All these potential crises may remain quiescent until one day an environmental change occurs. A loss of some kind is usually involved — loss of a crucial love object, a job, a body part, or some other source of self-esteem. At that time, and at that time only, a previously latent psychiatric disorder becomes clinically manifest.

In such instances, hospitalization may play a rescuing role, protecting

the patient from his own uncontrolled impulses and from the punitive responses of those who do not understand his predicament. The hospital provides him with a relatively rational input in place of the confusion in his own home, and with medications that ease his suffering and increase his self-control. In short, the hospital functions as an asylum in the finest sense of the word.

In the sheltered setting of the hospital, overt manifestations of mental disorder tend to melt away quickly. In place of the acute emotional decompensation that prevailed on admission, a state of remission sets in during which the patient may even be entirely symptom-free. However, it cannot be emphasized too strongly that this symptom-free state does not reflect a cure. All it signifies is that the patient is able to function in a more or less symptom-free state within the sheltered setting of the hospital. It provides no clue concerning his ability to adapt to his previously traumatic outside environment. No one understands this better than the patient himself, and that is why he is so often afraid to leave the hospital or why he tends to relapse as his discharge date approaches. In view of this, it should surprise no one that many patients discharged at this point in the treatment program relapse swiftly or commit suicide.

This simple sequence of events is subject to widespread misunderstanding. Unless the patient’s environment has also been improved,

he will not maintain his hospital-induced improvement. It is true that medications and a strongly supportive after-care program may help the patient to be more tolerant of his life stresses. But it makes no sense to omit entirely the environmental factor from the therapeutic equation.

In order for the environment to be more tolerant of the patient, he and his family must learn to relate to each other with more compassion. This requires time and it must be accomplished gradually. Therapeutic leaves of increasing length as well as overnight leaves must be professionally monitored, regulated, and modified as clinical conditions require.

APPLICATIONS

Admission to a mental hospital usually occurs through one of three routes. With "informal admission" the patient accepts hospitalization of his own accord. The exact same conditions prevail in this circumstance as if he had accepted hospitalization for a nonpsychiatric illness. He is free to leave at his own discretion, even against the advice of the physician. Most admissions to general hospital psychiatric in-patient units are of this type.

In the case of "voluntary admission," the patient voluntarily signs a certificate requesting admission. However, once the patient has accepted admission, the hospital is empowered by law to keep him hospitalized, against his will if necessary. The length of the involuntary stay in this instance

is usually in the order of one to two weeks and is carefully prescribed by law. This gives the hospital the opportunity to prevent discharge against medical advice when such an action might have serious consequences for the patient or those close to him.

Finally, “involuntary admission” is used when a patient in need of in-patient care is deemed to be a danger to himself or others but refuses to accept “informal” or “voluntary” admission. “Involuntary” admission occurs, then, when a member of the family or some concerned person in the community applies for help. In this instance one or two physicians (depending on local ordinances) examine the patient at the request of the “petitioner” and decide on the basis of the history and their findings if in-patient care is indeed unavoidable. In this instance, the hospital is empowered to retain the patient as long as the physicians treating him deem necessary. There are a variety of laws that protect the civil rights of these involuntarily confined patients. In actual practice “involuntary” confinement is infrequently used. If properly approached, most patients who require in-patient care can be prevailed upon to accept one of the other types of admission.