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HUMANIZING A PSYCHIATRIC WARD: CHANGING FROM DRUGS TO PSYCHOTHERAPY

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ABSTRACT: *During the course of a year the authors changed a psychiatric ward from primary reliance on drugs to an intensive psychological approach. There were both strong institutional supports and resistances reflecting the ambivalence attending efforts to develop more personal, humanized ways of relating to mental patients. An openward community setting evolved in which staff became highly accessible and caring, patients shared major caring and treatment responsibilities, and certain special psychological treatment techniques were developed. Many previously "untreatable" patients were involved and the improvement criteria were ambitious; the results suggest that such an approach is superior in long-term cost/benefit effectiveness to the prevalent "revolving door" programs which emphasize drugs and "dischargeability."*

Introduction

During the course of a year the authors and their colleagues changed a psychiatric ward from primary reliance on drugs to primary reliance on an intensive psychological approach. The evolution of the psychological treatment approach, revealing many of the resistances and hazards in the way of such programs, is presented in this article. In a forthcoming article, an approach to psychological treatment of severe depression is presented.[3] It is hoped that our accounts will encourage and stimulate further work with intensive psychological treatment of severely disturbed patients within hospital settings.

The Setting

The setting for our efforts was in many respects typical of psychiatric teaching hospitals. The hospital was physically old and decrepit. There was no air conditioning, though it was greatly needed, and the noise level was high because of the lack of carpets, drapes or soundproofing. Psychiatric residents and clinical psychology interns or fellows rotated through the ward every six months. Medical students and nurses in training rotated every four to six weeks. The permanent staff of each ward consisted of a psychiatrist who was ward chief, a clinical psychologist, a psychiatric social worker, an occupational therapist, and several psychiatric nurses and aides.

Prior to our beginning the new ward program, treatment throughout the hospital was characterized by heavy reliance on drugs, much more so, it was later revealed, than most staff realized. Nearly all patients were admitted through a psychiatric emergency room in the nearby general hospital. An independent researcher found that all of the many patients diagnosed schizophrenic were placed immediately on phenothiazines before they could be observed in the psychiatric hospital. Such established prescription regimens would then be carried on routinely by the resident on the ward. Virtually all patients, regardless of diagnosis, were quickly placed on some kind of medication to reduce symptoms, thus obliterating the opportunity to observe individuals in their

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natural condition. Further, the habit of placing patients on drugs was so ingrained that non-drug alternatives for the hastily diagnosed "schizophrenic" patients were considered "malpractice" by some residents.

In accord with the reliance on drugs, the main focus of staff concern seemed to be reduction of the patient's symptoms and early discharge, hopefully before thirty days when most insurance coverages ceased. Not surprisingly, the average length of stay turned out to be slightly less than thirty days. A nurse's performance tended to be judged by her superiors on the basis of whether or not the ward was quiet; thus, patients who were noisy often had their tranquilizing medications increased. Post-discharge psychotherapy was difficult to obtain. Patients were not transferred to the department of psychiatry's large outpatient clinic but were sent to a facility originally set up to provide group psychotherapy but which really was used only to dispense medications.

Psychological approaches were not impressive. Individual therapy was usually supervised by the resident's off-ward psychiatrist-supervisor who had little knowledge of the ward and was likely to concentrate, as did the resident, on the resident's outpatients. Some residents conducted "group therapy", usually without supervision. The hospital also provided occupational therapy and the social worker was utilized primarily for disposition and "after-care" planning. Almost all staff and patients were involved in daily "patient-personnel" meetings which like the group therapy often seemed without clear conceptual guidelines and goals. As in many psychiatric hospitals, "milieu therapy" was more a vague notion than a practical reality. However, on balance, the hospital would have compared quite favorably with the average, in Rosenhan's (1973) sample.

Beginning the New Ward Program

The new ward program began when the senior author of this article, Dr. D., became ward chief just prior to the annual July changeover of psychiatric residents. He informed the staff that he intended to establish a new policy. Whereas previously, the goal had been to reduce symptoms so patients could leave the hospital; now, the treatment goal for most patients would be for them to become psychologically stronger than they were *before* they had decompensated. In other words, the patients' own psychological abilities were to be increased to the point that they would be much less vulnerable to stress than they were before they were hospitalized. An important feature of this policy was that drug treatment with new patients would not be instituted until the ward had attempted to treat them psychologically, and such efforts had failed. It was emphasized that all behavior, that of the staff as well as the patients, was expressive of motives and meanings that influenced the clinical course of the patients on the ward. Ward staff initially reacted to the new ward chief's announcement with considerable apprehension. They expressed their doubts that a program that did not rely on drugs could be effective and they were anxious in their uncertainty as to how to proceed.

Specific Therapeutic Methods

An important feature of the ward was a special form of group psychotherapy. Each group met four times a week and each was composed of five to eight patients, the supervising psychologist (the co-author, Dr. W.), a psychiatric resident, and a psychology intern or postdoctoral fellow. The therapists-in-training and the supervisor met by themselves on the fifth day for a supervisory hour.

An important aim of group therapy was to clarify and bring about a change in the negativism of psychotic patients. This negativism was expressed directly and indirectly in three typical forms:

> "I am a hopeless case, therefore it makes no sense for me to participate or care about what happens, so leave me alone"
> or
> "My problem is that the world is rotten"
> or
> "I need something, but you can't provide it."

Until such negativism could be reduced, a therapeutic alliance could not be established, and individual psychotherapy could hardly be effective.

To cope with this problem, we made much use of irony, role playing and satire to demonstrate the absurdity of self-defeating assumptions. The following is an example of how the "I am a hopeless case" defense was sometimes dealt with in group therapy. Each patient

would be asked his or her opinion as to whether or not the other patients were hopeless. The patient being questioned would invariably say that none of the other patients were hopeless. Then when asked about himself or herself, the patient would affirm vigorously that he or she, however, was hopeless. The same procedure would be repeated with each patient in the group until each patient had maintained that he or she was hopeless while the others were not, and the absurdity of the situation became too evident to be ignored. After a while, the most resolutely hopeless patient would begin smiling despite the grimmest of intentions.

In a similar fashion, other typical defensive responses or inappropriate behaviors were focused upon and dramatized so that their invalidity and illogic would be made clear to the point of blatant absurdity. Many supportive, empathic and sympathetic communications were offered also, as patients developed more positive orientations which naturally drew such positive reactions. As a result of this process which was directed to the basic beginning dilemma of many psychotic individuals, patients tended to make constructive use of the individual therapy offered them.

Sometimes the entire group's attention would be focused by the therapists on a single individual for entire sessions at a time, often in conjunction with psychodrama-like playing out of important vignettes in a patient's life which we felt were central to the patient's core conflicts. Role playing of both the maladaptive original situation and a hypothetical adaptive situation was done regularly in sequence, occasionally over the span of as many as three sessions. This kind of concentration on an individual in the group is a major subject of Part II of this article and is detailed therein.

Individual psychotherapy was conducted by the residents three to four times a week with most patients, and was supervised by the ward chief, generally. The theoretical orientation was that of Artiss (1959) and Knight (1962). Residents were encouraged to work actively with their patients, challenging behavioral defenses verbally as well as offering emotional support and encouragement. They were taught to regard the patients' overt symtoms as communications and to use their own emotional response as their guide to understanding the dynamics of the therapy situation, as well as the content of the patient's message. For example, a resident might be helped to become aware of his rage at a patient who regularly used muteness to express anger and defiance. The resident's anger resulted from the threat to his or her self-esteem at being unable to exercise his "doctor" skills around which his esteem was based. The resident's resulting helplessness and suppressed fury was a re-enactment of the patient's feelings in dealing with controlling parental figures. Once the resident could acknowledge and understand his rage, he no longer felt trapped but could use this understanding to communicate with the patient. In the course of this work, the residents had many opportunities to gain insight about their own conflicts, as well as those of their patients. It was not until the ward milieu had developed fully into a psychological treatment unit that the roles and responsibilities of staff and patients could be clearly defined, however.

Development of the Milieu

The ward's development seemed to stem from our insistence that a psychological treatment approach be attempted prior to considering the use of tranquilizing drugs.

In the past, when the staff had to deal with an acute disturbance on the ward, they would often resort to drugs or to discharging the patient. Now they were instructed that a ward disturbance involved everyone and should be dealt with by the entire ward. A policy was established that the nursing staff could and should call a meeting of the entire ward any time they felt they needed help in dealing with a disturbance. As basic and routine as this procedure might seem to be, however, in practice, the nursing staff needed repeated encouragement to follow it, for reasons discussed below.

Staff learned about themselves, as well as the patients, at such meetings. For example, at one point most of the staff had expressed strong feelings that a particular patient should be discharged, although there was no evidence of improved functioning, because it was feared that the patient would remain in the hospital "forever." As a full discussion ensued, it became clear that the staff thought the patient (and others, as well) would become totally "dependent." When confronted with the physical reality of the ward, which was overcrowded,

noisy, and bleak, the staff began to see that their own wishes to be taken care of and treated as patients were playing dominant roles in their response. It also became possible to see that if, indeed, a patient preferred the hospital ward to the outside world, then the outside world must appear to be a very frightening place and that was the very problem we sought to treat.

Once the patients and staff, as a group, began considering the circumstances surrounding a specific incident, they could see that whether or not a particular patient's behavior got "out of hand" depended on whether the ward group wished it to get out of hand and, consequently, whether the group members were spectators, instigators, or moderators of the behavior. Often it was possible to point out a pattern of covert reinforcement of the "sick" behavior of a particular patient while his or her healthier behavior was ignored. It became apparent that subtle choices were being exercised by patients and staff alike.

It was very sobering to discover that the nurses and attendants had been insufficiently trained for a primarily psychological therapeutic role, such as our ward program required. Their training had been for the usual medical role and they were implicitly, if not explicitly, instructed to hide their feelings and maintain a "professional", *i.e.*, distant attitude toward the patient. When deprived of the pill-dispensing function, they seemed to feel that they had no other resources at their disposal. They did not trust their emotional responses and therefore could not make use of them to understand a given situation. Despite specific encouragement at staff "feelings meetings", it was only with great difficulty that nurses and attendants acknowledged the anger that they experienced toward patients. They felt quite guilty about these feelings and thought they meant that they were bad therapists. As we discussed this problem, everyone saw how hard it was to tolerate screaming and rage and, conversely, how much easier to tolerate apathy and depression. It became clear that in the past, staff anger had often been covertly expressed in recommendations that certain patients be put on drugs or given electric shock or transferred elsewhere. Recognition of their own anger, frustration, anxiety and dependency wishes was an important step for the entire staff. It enabled them to begin using their own feelings as a guide to what the patients were communicating and what was taking place in a given situation on the ward.

From the beginning of the new ward program, the nursing staff expressed a wish for more responsibility and decision-making power than they had in the old program, but when explicitly given that power and urged to call ward meetings on their own initiative, they were slow to do so. This slowness was directly related to their feeling a lack of competence to conduct meetings and their fear of the emotional flux of an expressive ward meeting. As the nursing staff's confidence increased, however, and they became more experienced in the use of their emotions as guides, it became a regular procedure for the nurses and attendants on duty to call ward meetings rather frequently, as they sensed the need for them.

Medical students and nursing students had been allowed in the past to form a treatment relationship with a particular patient for a relatively brief but significant period of time and then leave abruptly at the end of their six-week rotation. Clinical experience suggests that the loss of a needed person is often the trauma precipitating a psychotic episode. Unwittingly, these students had been reinstituting prior traumas without the skill or opportunity to help resolve them. Their abortive encounters reinforced a patient's tendency to withdraw and made future therapeutic relationships more difficult. Consequently, the practice of assigning patients to students of extremely limited stay was discontinued. Instead, the students were offered the role of functioning as part of the nursing team and working with the patient group as a whole in the various activities of the milieu program. For the medical students there was also the option of participating in the group therapy sessions. For the same reasons, psychiatric residents were assigned to the ward for an entire year and encouraged to continue with some of their patients on an outpatient basis the following year.

Having begun to change the roles of staff from relatively passive onlookers and drug dispensers to active, concerned, and personally caring roles, it was then possible to help patients become active, concerned, and personally caring instead of passive, drug-dependent and powerless objects.

Our daily, one-hour patient-personnel meet-

ings were increasingly influenced by the initiative patients began to take. Prior to the new program, patients' questions in these meetings were often simply turned back on them in a way that paralyzed thought and action and kept staff aloof. For example, a patient might ask, "What is this meeting supposed to be about?" A staff member would then say to the patient "What do you think this meeting is about?" The patient might be brave enough to venture an answer despite the implication that everyone else knows the right answer. He or she might say, "I think it's to try to help us but I'm not sure how," whereupon staff would ask other patients what they thought until the topic was changed. Patients were thus given to understand that there was no point in asking questions because you never got an answer. The defensive and destructive nature of such interchanges was pointed out to the staff who then were encouraged to tell the patients what they thought the meeting should be about and set an example by active participation. In response, gradually, the patients began to venture forth with ideas they had for improving the usefulness of the meetings and they were given the latitude to try almost any idea they recommended if the patient group as a whole seemed to be in favor of it. In October the ward milieu took a decisive turn in the direction of greatly increased patient responsibility and self-determination.

Opening the Door

During the first three months of its development, the ward had operated as a locked unit. Some of the sixteen patients had full ground privileges, others could go off the the ward only with an attendant, and some were restricted to the ward. The nurses' jobs involved a great deal of time scurrying to and from the door to let people in or out and checking to see who was on the ward. Patients broke out and "eloped" regardless of closed door regulation, and it became apparent that the closed door was exceedingly irksome to all staff. Other wards that made use of phenathiazines had their doors open much of the time. Our staff became increasingly insistent that they cease to be "jailors" and spend more time with the patients.

The ward chief felt strongly that establishing an open ward would sacrifice treatment possibilities for a significant number of patients who could not be held in the hospital long enough to get treatment underway. However, when faced with the intensity and unanimity of staff feelings against his position, he capitulated. A general ward meeting was then called, and the patients were asked if they wanted the door to be open. There was an overwhelming affirmative response, with the exception of two patients who were constantly escaping—they wanted it closed! The patients were told that we did not have the personnel to conduct an open-door ward without the patients themselves being involved; we needed their help in watching and accompanying whatever patients were acutely disturbed at the time. The patients readily agreed to this plan, and at the conclusion of the meeting the doors of the ward were unlocked and left unlocked from that time forward.

Not only was the open door policy greeted with much relief by the patients and the staff, but it led to a further development in patient participation. If the patients were to be assigned responsibilities in watching other patients and alerting the staff to other patients who became suicidal, they had to be included in the treatment planning and given knowledge of particular patients. The regular ward meetings with patients thus began to include more and more discussions of the status of individual patients until the time came when a therapist, if he or she became concerned about a patient, would bring that concern to the ward meeting to ask for suggestions and help.

By this time, there was a gradual but noticeable increase in the "family feeling" of the ward. There developed a sense that the ward was a unit where everyone belonged and where everyone was the object of care. Viewed in retrospect, this "caring" feeling may have been a more potent therapeutic force than any of the formal therapeutic activities. At times when the group focused on an individual patient, it seemed almost a palpable force. It arose, in part, out of the specific ethos of the small therapy groups: the role of each patient was to talk about his or her problems, to listen to others when they spoke of theirs, and to try to help one another. At the time of the open-door meeting, this ethos was extended and made explicit for the entire ward. The patients readily accepted this principle and referred to it frequently, confronting one another on matters that arose on

the ward. As patients became more involved in the treatment process, they would spontaneously carry on small group activities on their own. In one instance, group therapy work was carried on late at night with a particularly withdrawn, psychotically depressed woman, by the patients belonging to her regular therapy group. The next morning at the ward meeting, another patient complained: "Why didn't anybody wake me up so I could be in on it?"

Patients were often encouraged to share their feelings and were told essentially that it was good to do so. Yet in the initial phase of development of the ward program, staff did not share their own feelings, thereby conveying the opposite message to patients. It soon became apparent that getting staff to share their feelings with other staff, much less the patients, was our most difficult task. The staff, especially the nursing staff, had been accustomed not to show disagreement with one another publicly, or even to share irritation; they had been trained not to reveal their own feelings, attitudes or beliefs in the presence of patients. Only gradually, and with much reluctance, did the staff begin to speak up, and it was with some help from the patients that they did so.

By the end of October, the patients had become quite outspoken and took considerable initiative in ward functions. They had begun to run some of the patient-personnel meetings that were held routinely each morning. On some occasions the patients determined the topics to be discussed, the specific purposes of the meetings and even whether staff would play the roles of patients and patients would play staff roles during a particular meeting. We found that both staff and patients welcomed these temporary role reversals and that they gave a sense of perspective that simply could not be obtained any other way.

Opposition from other wards

The new ward program was supported by the hospital director. Furthermore, there was considerable positive feedback and encouragement from other service divisions in the department of psychiatry. Despite this, there was strong opposition from other wards in the hospital and from the nursing administration. News of our "no drug" policy had spread immediately throughout the other wards and brought forth an anxious and angry response from other personnel, not dissimilar from the anxiety that our own staff had experienced at first at the idea of managing psychotic patients without relying on drugs. The other wards feared the possibility that they would be required to do the same and they resented the implication that the new procedures being instituted were superior to what they had been doing. Consequently, the ward found itself vehemently criticized and had to devote considerable energy to fending off attacks from the rest of the hospital. Staffing vacancies were not filled by the hospital's nursing administration because prospective nurses and attendants were told that our ward was "experimental" and that the personnel there were "unhappy." The ward's acting head nurse found herself eating alone in the hospital dining room and other staff continually received messages of anger and criticism, often directed at the ward chief. Nurses on our ward found that they were being harshly criticized by the hospital's nursing administration office, harassed in a variety of ways and threatened with bad nursing evaluation reports. At the same time there were some staff on other wards who became positively interested in our approach.

Residents on the emergency psychiatric service supplied virtually all admissions to the hospital. These residents plus those who had been on the old ward attempted to shunt all "schizophrenic" patients away from our ward, declaring that withholding drugs from these patients constituted "malpractice." The "war" did have one benefit: under the constant outside attack, the feeling of group loyalty and cohesion on the new ward increased out of necessity. It was not until later, when the ward's position was more secure, that intragroup conflicts came to the fore.

The staff's hopes that the ward would "get into shape" and become "stable" was finally seen to be unrealistic. Involvement with patients meant allowing oneself to be vulnerable to the emotional onslaught that is often the medium of communication of these patients. Eventually, we realized that the emotional level of the ward would always fluctuate, and that lows and highs would tend to be the rule. The lows occurred out of frustration with particularly difficult patients and in situations in which the staff's own dependency wishes had become intensified. A sign of the latter was readily

apparent in the eagerness staff often exhibited to do the patient-staff role reversals described earlier. The highs came about in situations in which staff and patients felt a real identity, a oneness as people, a oneness based on the fact that the foundation of their being turned out to be love and not hate and that they could all function best as collaborators rather than adversaries. Such highs occurred quite often enough to balance the lows and at this stage the ward began attracting staff who wanted a meaningful psychological treatment role. The acquisition of a very capable and strong head nurse in the latter phase of the ward's development gave the nursing staff some of the leadership that they had been missing.

The easing of the struggle with the other wards made it more possible for the staff to express some of their own discomforts in staff meetings. It became clear that the staff needed a great deal of support and understanding just as the patients did. There had to be a place where the staff could clarify their feelings and receive encouragement and support from their colleagues. "Feelings meetings", usually called in the evening, became the means for such activity. These meetings helped resolve personal and interpersonal conflicts among the staff that had been interfering with their effectiveness.

Staff fatigue is a constant problem in working psychologically with psychotic patients and the staff often experienced the feeling of an overwhelming burden and of endless demand. However, when the ward developed to the point where the staff members could bring the treatment problems to the staff group or to the entire ward, we discovered that patients and staff could provide help, support, and creative solutions to treatment problems that the therapist was not able to solve alone. Staff, as well as patients, felt themselves to be part of a family and could draw on the group's resources and strengths as needed.

An unexpected result of the program was its marked influence on a number of the ward staff. Some experienced personal crises stemming from the necessity to confront their own feelings and goals. Those who chose to stay on the ward and face themselves experienced considerable personal growth. Most of the residents matured as professionals, a number of ward attendants decided to go on for further schooling, some excellent personal relationships developed, and we were led to conclude that the ward experience could be "therapeutic" for staff as well as patients. In the long run many staff experienced a strong desire to continue to have the kinds of involvement and personal satisfaction in their future occupational lives that they had experienced in the ward program.

The year of the new or "experimental" ward ended in midsummer with the turnover in residents, new and increased responsibilities assigned to one of us (Dr. W.) and a decision by the ward chief (Dr. D.) not to continue because of his obligation to complete a long term research project contracted before the ward program began. Finally, there were important financial considerations for the hospital which began to impose sharp limits on length of stay because of decreasing outside funding. Other wards had begun to emulate the "experimental ward" in some respects but without its full implications. We did, however, begin then to follow-up many of our ward patients and did intensive follow-up studies on a few of the most severely disturbed.

Therapeutic Outcomes

The "new ward program" was fully operative for ten months. During this period, there were a total of 51 patients treated; 20 patients were discharged in 30 days or less and the other 31 were on the ward more than 30 days. This latter group averaged 4.7 months of hospital stay. The first 20 patients represented mostly milder disturbances, most often neurotic depressive reactions with rapid symptomatic improvement. The other 31 patients represented much more severe disturbances usually, some of the kind that would have been transferred from other wards to a state hospital for "longer term care."

We did not start our program with a research effort that would have permitted us to make rigorous statistical statements about the overall results. There was no control group with which to compare our experimental group and we did not gather independently arrived-at evaluations of outcome. We were as much interested in the methods and dynamics of developing such a program as we were in the results. Furthermore, we had not anticipated much of the professional resistance which often preoccupied us in the early months and which we feel helped to

develop an understanding of why such programs are seldom developed. We did, however, attempt to follow up those patients who were in the program more than 30 days and whose disturbances had been relatively severe. While not suggesting that this data is in any way definitive, we regard it as more adequate than the usual criterion of "dischargeability" with no follow-up.

Table I shows the diagnoses of the 31 "long-term" patients together with ratings of degree of improvement by the authors. Each rating on our six-point scale was based on ward observation, plus follow-up observations after discharge. In several cases the authors interviewed former patients several months after discharge and, in a few cases, there was extensive follow-up including psychological testing and interviews as long as two years afterward. We emphasized follow-up observation in cases we regarded as especially severe. Each evaluation of improvement was based on a comparison of the patient's adaptation level *before* the crisis leading to hospitalization, to his or her adaptation level several months to two or more years after discharge. Thus, a patient might have a good clinical course on the ward but be rated low due to poor adaptation after discharge, unless we felt that life circumstances after discharge were much more adverse than before hospitalization. One such exception was a chronic schizophrenic man we rated 2, rather than 0 or 1, despite a rehospitalization within a year after discharge, which was precipitated by especially destructive behavior by his alcoholic mother. He was nevertheless much improved on second admission relative to his condition on first admission.

TABLE 1. DIAGNOSES AND IMPROVEMENT OF PATIENTS ON THE WARD MORE THAN 30 DAYS

Diagnosis	N	Degree of Improvement					
		0	1	2	3	4	5
Neurotic	9	1		2	4	1	1
Acute Schizophrenic	3				1	1	1
Chronic Schizophrenic	7	2		2	1	2	
Psychotic Depression	5					4	1
Manic Depressive	2			1	1		
Character Disorder	5	1	1	1	2		
Total N	31	4	1	6	9	8	3

The 0 rating position, representing no improvement, is illustrated by the case of a man who eloped from the ward after a few weeks' stay and, as far as we could tell, simply resumed his sociopathic behavior. Likewise, no improvement was shown by two chronic schizophrenic patients. Both patients were young but had long insidious psychotic disintegrations featuring considerable drug abuse (LSD) and had entered the hospital before the new ward program began; their treatment got off to very poor starts with several changes of therapists. Each subsequently required long-term treatment at another hospital before they could be safely discharged to outpatient treatment.

At the other extreme, illustrating the 5 position, is a woman whose psychotic depression had progressively worsened during the year before she entered the new ward program. At the time she entered the ward, she was almost mute, never expressed positive affect, and was delusional. The patient progressed on the ward to a distinctly nonpsychotic level. Six months after discharge, psychological testing (Rorschach, TAT, WAIS) and clinical interview revealed excellent reality testing, very creative use of her superior intellectual resources, and strongly adaptive social behavior.

An example of the 4 position is a 19-year-old girl who appeared to be psychotically depressed. The entire staff of the ward had predicted her future to be one of suicide or becoming an extremely long-term state hospital patient. She was treated intensively, especially in group and individual outpatient psychotherapy and married. Almost two years after discharge, it was reported by reliable sources close to her that she was doing fairly well, in marked contrast to the original prognosis, and she was interviewd by one of the authors who had similar impressions. A detailed account of this patient is given in Part II of this article.

The two character disorder cases rated 3 were treated painstakingly over a long period. They showed a definitely improved level of functioning several months after discharge but still needed considerable attention as outpatients to sustain further improvement from what were still fairly vulnerable positions. However, we felt that each of these patients would have gone on to chronic state hospital status or penal institutions had there been less ambitious treat-

ment.

Showing less, but still appreciable, improvement were two chronic schizophrenic patients, rated 2, who showed less vulnerability to major disablement months after discharge but were not impressive in their improvement overall.

The only patient we rated 1 was an older chronic alcoholic man who was severely suicidal with frequent previous hospitalizations. He made definite progress on the ward and did not commit suicide in the year following discharge, and did not require hospitalization. There was, however, no marked change in his precarious life style.

There are two further indices of treatment outcome. The rehospitalization rate for patients in our program was somewhat less than the going rate for the rest of the hospital, despite our choosing to treat extremely difficult patients on our ward instead of sending them to the state hospitals. During the initial summer one patient eloped and committed suicide. After that, for the ten months that the ward was in full operation, there were no suicides, no serious suicide attempts and only one permanent elopement. In contrast, another ward experienced three suicides during the same ten-month period. Also, as far as we have been able to tell, there have been no suicides of any of our patients since they were discharged several years ago.

Discussion

We do not regard the program described as the solution to the problem of psychosis or of other severe emotional disturbances. We do believe, however, that our experience suggests that much more is possible in the psychological treatment of severely disturbed patients than is usually believed. After less than a year of this program, we felt we had just begun to tap the therapeutic power that can be developed in the ward situation.

While our theoretical orientation was, in our minds, that of psychoanalytic ego psychology, a psychologist trained in gestalt therapy felt strongly that we were doing gestalt therapy; another psychologist, an acknowledged "expert" in behavior therapy, insisted that we were doing behavior therapy. One of us, Dr. W., often practiced psychodrama approaches. What finally appeared to be of overwhelming importance theoretically, was an evolving philosophy of power-building and power-sharing. It began to dawn on staff and patients alike that we had either to win together or to lose together and that we needed each person to be as powerful and competent as possible in order to maximize the effectiveness of our collective efforts. Thus, we would emphasize a theory of organizational development more than any specific "school" of psychotherapy.

The question remains, "Why are drugs the dominant treatment mode in most hospital settings?" In answering this question we would point to certain economic considerations on the one hand and to certain psychological factors on the other. In the short run, it would appear economic to hospitalize patients for less than thirty days; many insurance plans will not pay for more than this length of stay. Thus, rapid reduction of symptoms becomes the criterion for successful treatment outcome. Adequate outpatient psychotherapy afterward is usually lacking. Once these goals are set, there is a premium placed on any measures which will "restore" the patient to his prehospitalization level with minimum involvement of expensive hospital and staff time. The treatment which is still considered to be most useful in such efforts is drug treatment. Certain other goals of treatment, such as were established in our program, tend to be set aside in these efforts. The prevalent goals are strongly reinforced by the usual basis of reimbursement: bed occupancy, per se, for up to thirty days, rather than evidence of treatment effectiveness.

Among the appeals of drug treatment, there are some which are peculiar to the doctor-patient relationship. Kartus and Schlesinger (1957) have discussed how the "counter-transference potential" of the physician can be activated so that sedatives will be prescribed for nontherapeutic or antitherapeutic reasons. They advise that physicians be aware of the possible meanings of patients asking for sedatives and their own wishes to prescribe them. Deikman (1971) observes that remarkably little attention is paid to the unconscious motives of staff in prescribing phenothiazines and similar drugs and discusses the wish of staff to "disidentify" with such patients to avoid the communication of the psychotic's perspective; to avoid the intensity of psychotic affect and dependency wishes; and to express the unconscious rage that

is provoked in them when the patient frustrates their wish to "help."

The question may still be raised as to whether drugs should not be the treatment of choice for severely disturbed psychiatric hospital patients if they promote quick discharge, for more rapid discharge would seem to be economically advantageous. Quick discharge, however, really begs the question of treatment effectiveness since it does not say whether an individual will be able to function productively. In New York State, for example, it has been found that patients do not function productively when merely discharged, that enormous community problems ensue, and that patients often return to the hospital, thereby creating a "revolving door" effect which in the long run is more expensive. The "miracle" of drug treatment is then rather like the fable of the emperor's new clothes. Recently three excellent studies have been reported demonstrating that drug treatment may well be inferior to psychological approaches.

Bockhoven and Solomon (1975) reported the results of comparing two five-year follow-up studies on hospitalized persons, one on patients receiving modern psychotropic medication and the other on patients treated in the absence of psychotropic drugs. They state:

> The finding of no substantial change in the outcome of schizophrenic patients was not expected in view of the absence of psychotropic drugs during the entire 5 years of the Boston Psychopathic Hospital follow-up period, compared with the extensive use of psychotropic drugs at Solomon Center for both initial treatment on admission and the entire period of aftercare. This finding suggests that the attitudes of personnel toward patients, the socioenvironmental setting, and community helpfulness guided by citizen organizations may be more important in tipping the balance in favor of social recovery than are psychotropic drugs. . . . Their extended use in aftercare may prolong the social dependency of many discharged patients.

Carpenter *et al.*, (1977) showed a significantly superior outcome for acutely schizophrenic patients given psychosocial treatment and only sharply limited medication versus similar patients receiving the usual treatment emphasizing drugs. These authors remark that "the treatment of schizophrenia has become so extensively drug oriented that a significant impediment has arisen to the exploration of alternative therapeutic approaches."

Evidence of the potentially greater economy offered by the psychological treatment of severely disturbed persons is found in the work of Karon and Vanderbos (1975). They have shown in their studies of treatment costs of psychotherapy versus medication for schizophrenic patients "that despite the expense of psychotherapy, there were savings of 22% to 36% in total treatment costs because of the shorter hospitalization of patients." We would not be surprised if similar studies with psychotically depressed individuals would also show savings for the psychotherapy approach. Arieti (1974) has stated, "In my experience psychotic depressions tend to recur unless adequately treated with psychotherapy." And that "Drug therapy . . . in my experience is not sufficient in most cases to cure affective psychoses even from the manifest symptomatology."

Psychological approaches in hospitals have long had the advantages of considerable thought. For example, the work of Cumming and Cumming (1970) presented excellent theoretical and practical approaches to psychiatric hospitalization. It becomes difficult then to fathom why it is that psychological approaches are so neglected in practice except that drugs represent the wish for a cheaper, easier way of dealing with difficult patients. In our opinion, the extreme reliance on drugs is wishful self-deception on the part of the psychiatric profession.

In the long run, a practical approach to psychological treatment of severe emotional disturbance will have to be based on revised concepts of what constitutes good treatment and an implementation of these concepts in treatment plans. Such concepts would emphasize outcome measures of ability to function productively, not merely decreases in disturbing symptomatology and quick discharge. Diagnostic assessment, which now is so limited to superficial observation of behavioral proclivities should emphasize meaningful predictive measures of an individual's ability to think and to behave adaptively, both before and after treatment (Whitaker, 1973; Whitaker, 1978; Whitaker, in preparation).

Reimbursement plans would emphasize outpatient services both as preventive and after-hospital treatment. We believe that adequate reimbursement for follow-up psychotherapy would make it possible to shorten hospital stay compared to our program.

For the present, psychological treatment of severely disturbed individuals will have to be accomplished in special settings where appropriate administrative support, financial backing and suitable personnel are available.

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