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Edited by Michael I. Casher , Joshua D. Bess
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Manual of Inpatient Psychiatry

Second Edition

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Second Edition

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Every effort has been made in preparing this book to provide accurate and up-to-date information that is in accord with accepted standards and practice at the time of publication. Although case histories are drawn from actual cases, every effort has been made to disguise the identities of the individuals involved. Nevertheless, the authors, editors, and publishers can make no warranties that the information contained herein is totally free from error, not least because clinical standards are constantly changing through research and regulation. The authors, editors, and publishers therefore disclaim all liability for direct or consequential damages resulting from the use of material contained in this book. Readers are strongly advised to pay careful attention to information provided by the manufacturer of any drugs or equipment that they plan to use.

About the cover: Van Gogh had several stays in the hospital Hôtel-Dieu-Saint-Espirit in the town of Arles in southern France in 1888 and 1889. In this painting, Van Gogh depicted the hospital courtyard in his characteristic later style of vivid colors and high expressivity. Even though he was suffering from severe mood symptoms and psychosis around this time, the hospital clearly offered Van Gogh refuge and respite and was a source of artistic creation and production. After several months in Arles, Van Gogh admitted himself voluntarily to a longer term asylum in nearby Saint-Rémy-de-Provence. That domiciliary treatment site must have served to further stabilize and protect Van Gogh, as it was soon after leaving there that he took his own life.

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Preface to the Second Edition

I should have no objection to go over the same life from its beginning to the end: requesting only the advantage authors have, of correcting in a second edition the faults of the first.

Franklin, B. (1859). Benjamin Franklin: His Autobiography: With a Narrative of His Public Life and Services. New York: Derby & Jackson.

The opportunity to present a second edition of one's work is – like second chances in general – a gift and a challenge. So it was with both pride and trepidation that we received word from Cambridge University Press that the first edition of our *Manual of Inpatient Psychiatry* had garnered a sufficiently positive reception as to warrant an updated reprise. Once you finish a project such as the *Manual*, its fate is out of your hands. Indeed, we were unprepared for some of the uses of our book, such as it being a favorite of neurologists studying for their board exams and needing a review of major serious psychiatric illnesses. Of course, the *Manual* found a significant audience in medical students rotating on psychiatry, and with early-year residents seeking a grounding in inpatient work for their extensive periods of training on inpatient units.

But the field of psychiatry – and inpatient psychiatry in turn – has moved on in the past decade, with advances in our understanding of mental disorders leading to new emphases and fresh approaches in treatment, and an attempt has been made to incorporate salient aspects of these trends and developments into this edition. The content of this second edition has also been influenced by pointed yet helpful comments from respected members of the psychiatric community who have drawn attention to areas of inpatient psychiatry that were short-shrived – or, frankly, even neglected – in the earlier publication. Thus, the reader of this second edition will find, for instance, a section on dissociative processes as they relate to inpatient work, the modern view of borderline personality disorders and their treatment, inclusion of innovative treatments for depression (including chronotherapy, neuromodulation therapies, and ketamine), discussion of the issues surrounding chronic traumatic encephalopathy, heightened attention to the medication conundrums encountered when treating agitation in dementia, and further elaboration of the special challenges involved in treating young adults

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on an inpatient unit. Nonetheless, modesty and honesty mandate that the limitations of this rather thin volume be pointed out – as was acknowledged in the earlier version – with the hope that treating clinicians will continue to appreciate the overview of illnesses commonly seen on inpatient units, and that readers will be motivated to visit some of the primary references at the end of each chapter, and to stay alert also to the ongoing stream of literature documenting developments that relate to the subspecialty of inpatient psychiatry.

The reader will undoubtedly note that the otherwise comprehensive and incisive history of American psychiatry written by our esteemed colleague and medical historian/psychiatrist Laura Hirshbein stops short of inclusion of the last decade of our field. A mere listing of some of the trends of recent years certainly will not reflect the same command of the historical period as the *Manual's* Foreword. Nonetheless, clinicians taking an “aerial view” of our field today would likely point to a number of inclinations and ongoing directions in psychiatric practice as noteworthy. This list would – arguably – include: advances in understanding the genetics of mental illness; the burgeoning knowledge of neural circuits reinforcing a paradigm shift toward a view of psychiatric illnesses as brain disorders; the ongoing vast research network that supports the focus on the biological underpinnings of mental illness; a continued shift in psychiatric training and practice toward evidence-based and diagnosis-focused psychotherapies, and an associated “outsourcing” to nonpsychiatrists of psychotherapy generally and insight-oriented approaches more specifically; heightened awareness of issues related to sexual, gender and other minority groups with the concomitant need for psychiatric care that affirms and respects diversity and inclusion; the near-exclusive use of the electronic medical record (EMR) and the growing backlash against its hegemony as contributing to dehumanizing the therapeutic relationship and to “burn-out” in clinicians; and the ongoing undeniable impact on psychiatric treatment of the pharmaceutical industry and insurance carriers (which operate synergistically to dictate choice of treatment and limitations on treatment length and intensity). This list could be expanded further (perhaps even including the rise of digital technologies and social media and their influence on psychiatric practice), but additional points would likely only bolster a view of the state of psychiatry at the end of this decade as a mixture of welcome developments in the knowledge base and associated treatment options alongside frustrating hindrances to excellent care. With regard to the field of inpatient psychiatry, we can only say that it has not been unaffected by these trends – both the negative and the positive. And, as there will always be patients in states of acute distress who cannot be managed safely and effectively outside the structure of a hospital environment, inpatient psychiatry will maintain its crucial role in the overall system of psychiatric care and will have to survive any impingements while

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embracing the advances in the field. It is not clear how inpatient psychiatry will meet its challenges and evolve in the future, or what form this branch of psychiatry will assume. However, the level of dedication of the young clinicians embarking on their psychiatric careers gives some reassurance that the imperative for high-quality inpatient treatment of the major mental disorders will continue to be met for years to come.

Acknowledgments for the Second Edition

In addition to the obvious essential contribution to this edition provided by the excellent chapter coauthors, all of whom are superb clinicians and teachers, we wish to acknowledge the extraordinary editorial assistance provided by Kyra Sutton of the University of California at Berkeley. Thanks are also warranted – once again – to Cambridge University Press for their support for and encouragement of this project. Dr. Casher also wishes to highlight the encouragement and mentorship he received during his years at the University of Michigan from his colleagues Michael Jibson and the late (and greatly missed) Kenneth Silk.

Foreword: American Inpatient Psychiatry in Historical Perspective

In 1847, Horace Buttolph, one of the early members of the Association of Medical Superintendents of American Institutions for the Insane (AMSAIL, now called the American Psychiatric Association, APA),¹ outlined the ideal treatment for individuals with the condition known at the time as insanity. Appropriate care for patients involved placement in a carefully designed building with a supportive environment and a trained staff. Buttolph emphasized that this atmosphere of care and support was dramatically different from that experienced by insane individuals in the past, who “were treated as outcasts from society, as alike unworthy of the care of friends, and the sympathy of their kind. By some, they were supposed to be possessed of evil spirits, and exorcism resorted to for their relief, by others, they were deemed sorcerers, and burned at the stake, without even a form of justice in their behalf” (p. 371 [1]). Buttolph encouraged national agreement on the humane care for the insane, “until the enlightened benevolence of modern times, has done all in its power to relieve the dark picture of their suffering and neglect, in the history of the past” (p. 378) [1]).

Many modern individuals (including some mental health professionals) now view nineteenth-century asylums as specters of the dark history of psychiatry. But at the time of its origin, the asylum was viewed as a revolutionary and beneficial institution. Indeed, for the first century after the founding of the APA, members celebrated the history of the asylum as the story of progress in the care of the mentally ill. Henry M. Hurd’s *The Institutional Care of the Insane in the United States and Canada*, one of the first histories of American psychiatry, explored the origins of psychiatric hospitals across the nation and provided individual histories of all the nation’s institutions [2]. In hindsight today, it might seem odd that the history of institutional psychiatry preceded that of psychoanalysis [3], but in fact the history of inpatient psychiatry is the history of psychiatry itself. Before hospitals became central locations for treatment of medical illnesses [4], psychiatric institutions served major social and public health functions in the United States.

¹ The Association of Medical Superintendents of American Institutions for the Insane was founded in 1844 and changed its name to the American Medico-Psychological Association in 1892. It became the American Psychiatric Association in 1920. The journal associated with the organization began in 1844 as the *American Journal of Insanity*, but Became the *American Journal of Psychiatry* in 1920.

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Much of the terminology has changed in the treatment of the mentally ill over the last two centuries. In the nineteenth century, it was common to talk about mental alienation or insanity rather than mental illness, while psychiatric hospitals were frequently called asylums or institutions for the insane. The reasons why patients would be identified as in need of treatment changed, as social and professional interpretations of individual behavior shifted [5]. Treatments have also changed, from moral therapy, to active somatic treatments such as hydrotherapy, convulsive therapies and lobotomy, to medications. Further, the focus of American psychiatry has shifted, from a nineteenth-century emphasis on institutional care through a mid-twentieth century move toward addressing the problems of neurotic outpatients, to the modern broad, encompassing view of psychiatric illness in the population. Yet throughout most of the last two centuries, psychiatric hospitals of some kind have been critical to the care of mentally ill individuals.

The history of inpatient psychiatry in the United States reminds us that we have always practiced at the nexus of patient difficulties, family concerns, state and federal policies, and broader social factors that affect our treatment of the mentally ill. Psychiatrists have always had to advocate for mentally ill patients and balance the benefits and drawbacks of psychiatric institutions. Today, at a time when teams of mental health workers in psychiatric hospitals are attempting to grapple with the fast pace, enormous demands, limited reimbursement, and complicated patient populations inherent in current inpatient psychiatry, it is important to reflect on how we got here. In the cycles of history, we have come around once more to a time when we need to advocate for inpatient psychiatry and to make the observation that this treatment setting requires special expertise.

1830s–1900: Moral Therapy

Although the first few institutions to house the insane were opened in the eighteenth century, the impetus for states to build asylums for the insane came from reform movements in the middle of the nineteenth century [6]. One of the most vocal and active reformers in this time period, Dorothea Dix, traveled around the country and beseeched congressmen and community leaders to pay heed to the plight of the insane [7, 8]. Dix emphasized that these unfortunate individuals were often sequestered in prisons and poorhouses, or even left out on the streets to fend for themselves. Dix advocated for the construction of institutions for these individuals that would provide structure, security, and a healing environment. In her reform endeavors, Dix often partnered with members of a newly organized medical organization, the AMSAII (now the APA) [9].

Dix and the members of the AMSAII shared a conviction that the insane required appropriate institutions – asylums – to protect them from the harsh

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social and economic realities that contributed to (or caused) mental derangement [10]. At the time when Dix and others were active in reform efforts throughout the United States, institution building appeared to be the most progressive and humane measure to help people in need [11]. And Dix and her cohort of reformers succeeded in spurring state legislations to construct facilities for the insane across the country by the beginning of the twentieth century [2].

Historian Patricia D’Antonio has pointed out that the mid-nineteenth-century insane asylum was an institution based on negotiations between family and emerging psychiatric ideals and practices. Encounters among patients, staff, and families were not incidental parts of the treatment but rather these interactions constituted treatment within the therapeutic environment [12]. As historian Nancy Tomes has masterfully illustrated, the idea behind mental institutions in the nineteenth century was that patients experienced a moral environment – characterized by healthy staff relationships, good food, pleasant surroundings, and productive activities – in order to resolve their insanity. Most nineteenth-century asylums were modeled on the example set by Pennsylvania psychiatrist Thomas Kirkbride at the Pennsylvania Hospital for the Insane, where the physical architecture and internal organization influenced generations of psychiatrists. At the head of an institution on the Kirkbride model was the superintendent who acted as a father figure. His staff, including the heads of the male and female departments, were also members of the family and helped to govern. The atmosphere of culture and civility was intended to illustrate to the patients the appropriate way to behave in society. Presumably the example they experienced while in the asylum would help them become adjusted to life outside [13].

It is remarkable from our distance in time to reflect on public attitudes toward insane asylums in the nineteenth century. Although we might think of patients locked away and forgotten, the reality appears to have been quite different for many. As Tomes has described, patients within Kirkbride’s asylum often accepted and appreciated the care they were provided. They understood their role within the institution, and wrote to Kirkbride to seek advice even after discharge. Kirkbride’s associates with the AMSAI shared the expectation that their services and their role within the institution would be valued by the patients, and patients often fulfilled that expectation. In 1849, for example, members of the AMSAI toured several local mental institutions in New York in the course of their annual meeting. At the New York State Lunatic Asylum, a patient (and former minister) spoke for an assembly of more than 300 patients to express gratitude and support to the visiting members of the association: “The presence of a voluntary association of medical gentlemen devoted to the noblest branch of the healing art, the care and recovery of the diseased mind, is calculated to awaken sentiments of gratitude and respect. And for myself and fellow patients, I would greet you

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with a respectful and cordial welcome ... our duty to that unfortunate class of our fellow citizens who are afflicted with insanity, seems to demand that they should not only have the benefit of all that wealth can furnish for their comfort but also of the highest medical wisdom and skill which those can secure to whose care they are committed by their friends as an important trust" (pp. 12–13 [14]). Certainly at least some patients were able to understand and appreciate that they were experiencing the best that American psychiatry had to offer at the time.

But not all patients in the nineteenth century were able to receive care from national leaders in psychiatry or stay in well appointed asylums. Historian Ellen Dwyer compared the care of patients in two nineteenth-century asylums and found that patients experienced radically different courses of illness and treatment. Although psychiatrist leaders in the best institutions likened their asylums to large families, patients in less elite locations might have experienced their stay as more like a prison sentence. While some institutions took care of patients who were more acutely ill and attempted to discharge them within weeks to months, other facilities took on chronic cases in which the hospital stay might last for years to decades [15]. As historian Gerald Grob has observed, overcrowding and increasing numbers of chronic cases made the reality of asylum life much less than the ideal in some institutions [6].

Not only were experiences different based on patient class and illness course, but also race and region played a large role in institutional psychiatry in the nineteenth century. As Peter McCandless has described, the history of the care of the insane in South Carolina illustrates the broad disparities in asylum experiences due to race and social structure. Before the Civil War, few black patients were admitted to the South Carolina asylum as their behavior was effectively controlled within the institution of slavery, while most white insane individuals had sufficient community support to avoid institutions. After the war, however, South Carolina experienced a rapid decline in economic power as a whole, and insane individuals were less likely to be cared for by their families. In addition, the state asylum began to accept black patients in segregated, inferior wards. In this environment, it was hard to believe that the environment was therapeutic for anyone, especially black patients [16].

Though nineteenth-century patients and psychiatrists generally shared a conviction that institutions were helpful and humane, the profession by the early twentieth century began to shift their attention away from the asylum. Many psychiatrists by the turn of the century experienced loss of control over their institutions as state mental health offices began to dictate policy [17]. Also, as historian Elizabeth Lunbeck has described, some in the profession began to look beyond the confines of psychiatric institutions to promote psychiatric expertise throughout society [18]. In addition, psychiatrists became increasingly aware that the institution itself – especially the detail around building maintenance – was drawing criticism from other medical

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professions, including psychiatrists' closest professional competitors, neurologists [19, 20]. Critics – including neurologist S. Weir Mitchell who addressed the professional association's meeting in 1894 – accused American psychiatrists of being more interested in the maintenance of their buildings than the care of their patients [21]. It was not enough to put patients in grand institutions and expect them to get better. Psychiatrists needed to do more for the patients.

1900s–1960s: Treatment in the Hospital

By the early twentieth century, the promise of psychiatric cure through institutional care was beginning to dim. The numbers and types of institutions were growing at a high rate and some kinds of individuals appeared relegated to custodial care rather than treatment [22]. In a few locations, research-minded psychiatrists created new kinds of institutions, psychopathic hospitals, to permit shorter hospital stays and promote research and active treatment. But though these hospitals – including the State Psychopathic Hospital at the University of Michigan, the Boston Psychopathic Hospital, the New York State Psychiatric Institute, and the Henry Phipps Clinic at the Johns Hopkins University – were influential, they did not provide the bulk of psychiatric care to patients in the twentieth century [18, 23, 24]. Instead, the major change during this time period was that large psychiatric institutions, now mostly public and private mental hospitals, tried to meet the challenges of care for increasing numbers of patients at the same time that they seized opportunities for treatment innovation [25].

As historian and psychiatrist Joel Braslow has described, in the first half of the twentieth century American psychiatrists used somatic therapies on hospitalized psychiatric patients, including hydrotherapy, malarial fever therapy, sexual sterilization, and convulsive therapy [26]. Hydrotherapy, which originated in the nineteenth century, involved immersing patients in large tubs of water and/or wrapping them in wet sheets. Malarial fever therapy (in which patients were inoculated with serum from patients with active malaria) was used to treat patients with tertiary syphilis after it was observed that the high fevers in patients with malaria appeared to kill the organism responsible for syphilis. Sexual sterilization, most often performed in women, was intended to remove the sexual urges that psychiatrists believed fueled some psychoses [27]. All of these treatments, including convulsive therapy – one form of which is in use today – were intended to tackle the obvious and troubling problem of severe agitation in hospitalized patients. These interventions appeared to be helpful, scientific, and offered the promise of genuine treatment of cases that previously appeared hopeless.

Practitioners (as well as the public) were especially enthusiastic about convulsive therapy, including insulin coma therapy, metrazol therapy, and

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electroconvulsive therapy (ECT). Insulin coma therapy, which came about after the discovery of insulin in the 1920s [28], involved having patients receive increasing doses of insulin to the point that they went into a coma and/or experienced convulsions before they were revived with a sugar solution. By the 1930s, psychiatrists who worked with this technique proclaimed major benefit to severely ill patients, especially those with schizophrenia [29]. Other theorists and practitioners developed alternative ways of producing convulsions, which also seemed to help patients, including use of the drug metrazol in which individuals with manic depressive psychoses and involuntal melancholia appeared to respond best [30].

Of course, the most well known physical intervention to be developed and used in the context of psychiatric institutions was ECT. Although ECT originated in Italy in the 1930s, ECT techniques and practitioners spread rapidly throughout the world by the 1940s [31]. Electroconvulsive therapy enthusiasts were aware of the potential dangers of ECT (which at the time of its introduction included fractures as anesthesia was not routinely given until the 1960s), but the treatment offered hope for patients who were so ill that they could not leave psychiatric hospitals. Although we now tend to think of ECT and psychotherapy as almost completely opposite, practitioners in the 1940s and 1950s imagined a more fluid relationship among the treatment modalities. For example, at the time when psychoanalytic concepts became more prevalent within American psychiatry [32], many interpreted the action of ECT in psychodynamic terms [33].

Somatic therapies flourished in psychiatric hospitals in the first half of the twentieth century partly because psychiatrists were desperate to be doing something to help their patients. As conditions worsened in the hospitals, some psychiatrists became even more aggressive with their interventions. By the 1940s, increasing numbers of chronic and older patients made overcrowding in hospitals worse [34]. Further, journalistic expose's of hospital environments created public awareness and pressure on hospital physicians to take action [35]. As historian Jack Pressman pointed out, hospital overcrowding, deteriorating hospital conditions, and poor prognosis of patients led to increasing professional and public enthusiasm for heroic therapies – including frontal lobotomy. Although we now view the history of lobotomy as a dark episode in psychiatry's past [36], Pressman explained that many psychiatrists in the 1940s saw the introduction of psychosurgery as a promising development [37]. Indeed, lobotomy and shock therapies were concrete, physical therapies that could be measured, they addressed the severity of the problems of the mentally ill in institutions, and they appeared to represent application of scientific thinking to psychiatric problems. For practitioners and researchers who used the efficacy standards of the time [38], these somatic therapies worked.

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Although most of the somatic treatments developed in twentieth-century institutions did not last in psychiatrists' therapeutic repertoire, the hospital setting provided the impetus for our most lasting intervention – psychiatric medications. While institutionally based psychiatrists were not shy about using ECT and/or lobotomy for seriously ill patients, these interventions did not succeed in managing all patients. In the years after World War II and the worldwide success of penicillin, pharmaceutical companies began to look to expand their medication offerings [39]. Psychiatric hospitals appeared to be an ideal location in which to test new pharmaceutical agents – the populations were large, the existing treatments had not removed the problem of the seriously ill, and it was easy (in the days before informed consent and Institutional Review Boards [IRBs]) [40] to give medications to patients to see what would happen [41, 42].

Medication development in psychiatric hospitals not only led to the introduction of major classes of drugs (beginning with chlorpromazine and imipramine), but also helped to classify psychiatric patients. Through medication trials in the 1960s and 1970s, patients who responded to the different drugs were grouped into separate diagnostic categories [43, 44]. Their symptoms were then counted and listed, which led to the symptom-based diagnoses in the watershed third edition of the *Diagnostic and Statistical Manual* (DSM-III) in 1980 [45]. As Joel Braslow and Sarah Starks have further described, the introduction of psychiatric medications to hospitalized patient populations also expanded the number and type of patients who were potentially helped by psychiatric interventions, including those with everyday problems of living [46].

The introduction of medications, as well as the shift of many older patients out of psychiatric hospitals and into nursing homes, helped lead to the decline of psychiatric institutions as the major centers for psychiatric care [47]. For the first time, large numbers of patients were discharged from the hospitals and many returned to their communities. Further, social and cultural changes in the United States helped to translate the older criticism of overcrowded institutions into a widespread critique of psychiatric hospitals in general. Since the 1960s, psychiatric hospitals have been the target of widespread hostility, and their past was condemned as well as their present.

1960s–1980s: Community Care

In 1963, President John F. Kennedy signed the Community Mental Health Centers Act, which formalized the shift in mental health policy priority from institutions to outpatient care. Yet as historian Gerald Grob has pointed out, community mental health centers could more easily deal with neurotic outpatients than the seriously mentally ill patients who had been in hospitals. In the 1960s, hospitals began to transfer patients out of the hospital and into

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communities that did not have the resources to handle them [48, 49]. Not only were the communities not set up for the sickest patients, but also there were fewer providers willing to take on their care. By this time period, more psychiatrists had become entranced by the possibilities of psychoanalysis and outpatient practice [32, 47]. The flood of both patients and practitioners away from institutional settings led to major social problems. By the 1970s and 1980s, especially in places such as New York City and Los Angeles, it was clear that many patients were failing to make an effective transition from institutional care to community living [50]. Indeed, the flow of patients back onto the streets and into the jails was reminiscent of the social plight that Dorothea Dix had attempted to address more than a century earlier [51].

But there was nothing inevitable about the problems that resulted from the deinstitutionalization movement, and in fact the abandonment of the hospital as part of the transition toward community care was not necessary. As historian John Burnham has pointed out with the example of the mental health system in Topeka, KS, it was possible for the community mental health center and hospital to partner in the process of getting patients help and support across the spectrum of care [52]. But though the continuity between hospital and community worked in Topeka (perhaps because of the influence of the Menninger family) [53], the Topeka model was not widely emulated in the United States due to widespread rejection of state psychiatric hospitals and a widening conflict between state and federal mental health policy [54].

Indeed, psychiatric institutions appeared so problematic to critics and social commentators by the 1970s that even their histories were rife with criticism. Theorists such as Michel Foucault in France and David Rothman and Andrew Scull in the United States described the history of psychiatric hospitals as the history of state-sanctioned repressive and dictatorial practices directed at vulnerable individuals [55, 56, 57]. Antagonism toward mental hospitals was taken up by growing numbers of individuals who protested psychiatry in general [58]. Emerging patients' rights groups also strongly suggested that psychiatric hospitals did not help the mentally ill, and some argued that hospitals were more like prisons than healing institutions [59, 60].

For those hospitals that did remain, the environment inside and outside the institution became contentious. As patients demanded rights within psychiatric hospitals, changes in commitment laws formalized civil proceedings for patients who appeared to be mentally ill and in need of treatment [61]. Further, hospital beds funded by states significantly declined while beds within private hospitals increased [62]. Although mentally ill individuals still required periodic hospitalization, these episodes of care were not discussed often within national professional venues. Leaders of the psychiatric profession focused on increasingly complex issues such as federal support for mental health research, while others emphasized psychiatric diagnostic systems and

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development of further medications for mental illness [63, 64]. Few in organized psychiatry were taking up the issue of hospital care as the number of available psychiatric hospital beds continued to shrink across the country.

During the decades of state and national focus on outpatient mental health care, psychiatric hospitals were seldom discussed and were not incorporated into policy discussions around the mentally ill. But even as many in the profession had little or no interest in institutional care, small groups of psychiatrists continued to insist that psychiatric hospitals could play an important role, and that special interventions and techniques were necessary in this setting [65, 66]. Early in the twentieth century, psychiatric institutions had begun to actively employ staff such as social workers and activity therapists in order to enhance patients' experiences in the hospital [67]. By the 1960s and 1970s, hospital-based psychiatrists were emphasizing the importance of interdisciplinary work and the combination of somatic, group, and psychotherapy techniques they found ideal in this setting [68]. By the 1970s and 1980s, as state psychiatric hospitals continued to close and move their patients into the community, psychiatric units of general hospitals became increasingly important to mental health care [69]. In addition, health service researchers pointed out that the remaining state facilities were serving some purpose in the broad context of psychiatric care [70]. Although many psychiatric hospitals by this time period employed private practice models (in which private practitioners had admitting privileges to inpatient units), some dedicated psychiatric staffs and academic centers worked to develop a consistent hospital environment for the patients who passed through the revolving door [71].

Reinvigorated Inpatient Psychiatry

At the same time that psychiatric hospitals' role decreased in the care of the mentally ill, the role of the general medical hospital changed as well. Although technological changes and advances in treatment expanded, the rising costs of hospital care and the influence of third-party payment decreased hospital lengths of stay [72]. As a result, the patients in general hospitals over the last 20 years have been increasingly sick with more and more rapid turnover. In this context, it has become evident to many medical specialties that patients in the hospital require a more intense level of care and greater expertise [73]. A group of general physicians founded the National Association of Inpatient Physicians in 1998 (the organization changed its name to the Society of Hospital Medicine in 2003) in order to address the increasing acuity of hospitalized patients [74]. In the last decade, the concept of the hospitalist – a physician who specializes in the hospital treatment of the ill – has become much more common in general medical care.

In psychiatry, too, a small but growing number of psychiatrists have begun to reclaim hospital-based psychiatry with the same model as the general hospital

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specialist [75]. Modern-day hospitalists have also emphasized the importance – perhaps even the centrality – of the acute care psychiatric hospital to the mentally ill. Further, hospitalist models are increasingly dominating residency training [76]. As has been clear for more than a century, psychiatric institutions provide potentially ideal places to engage in meaningful research to develop new and more effective treatments. Further, the intensive nature of inpatient care allows for engagement with patients on a different level than the more sporadic contacts in outpatient care. But with the reinvigoration of hospital psychiatry, current practitioners inherit the long history of American psychiatry as a whole and continue to face opportunities as well as challenges in this work.

Although many of the challenges inherent in inpatient psychiatric care are not new, they remain important and require ongoing attention on a personal and a policy level. First, gender, race, and class continue to affect patients' hospital care experiences, despite well intentioned physicians and staff. All major psychiatric treatment innovations, from ECT to lobotomy to medications, have been given more often to women than to men in psychiatric hospitals [26, 37, 46, 77], while men formed the bulk of the patient group treated for alcohol and drug problems [78]. In addition, the ways in which physicians have traditionally understood and treated patients based on race have skewed their interpretations of normality and disease [79, 80]. As Stephen Jay Gould reminded us, it is important to understand the ways in which our culture and society frame our expectations about individuals and the interventions they appear to need [81].

Not only do gender and race considerations need to be part of careful inpatient psychiatric care, but also research opportunities can blind us to the risks of investigating acute and high-risk patient populations. History reminds us that it is important to remain humble and not to expect that one radical solution exists for the problem of mental illness [82]. As the history of lobotomy illustrates, a sincere desire to help seriously ill patients can lead to drastic interventions without adequate checks and balances [37]. Even now, as David Healy has pointed out, there is significant potential for psychiatrists to become too enamored of the power and influence associated with the pharmaceutical industry and its sponsorship of research without adequate concerns for the patients who might experience harm from recklessly marketed drugs [83].

Finally, inpatient psychiatry in the twenty-first century involves layers of challenges unimaginable to psychiatrists from more than a century ago. While psychiatric hospital leaders in the early twentieth century pioneered in tabulating patient data and gathering statistics, they could not possibly have foreseen the quantity and diverse audiences of modern documentation requirements. Further, while hospitals in the past struggled with finances and the balance between paying and charity patients [6], our current mix of public and private insurers has led to a maddening maze of reimbursement policies that encapsulate the conflict between insurers' desire to pay as little as possible and hospitals' efforts to maximize payments [84]. While our nineteenth-century predecessors complained about

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having to answer to the authority of state governments, hospital boards, and professional organizations, they did not have the multitude of involved groups peering over their shoulders the way that current hospital psychiatrists experience. Even as our methods for managing information have evolved, so have our obligations to share information with different parties expanded.

Early twentieth-century Harvard philosopher George Santayana made a now well known comment about the value of remembering history. It is worth looking at the few sentences preceding his famous comment: “Progress, far from consisting in change, depends on retentiveness. When change is absolute there remains no being to improve and no direction is set for possible improvement: and when experience is not retained, as among savages, infancy is perpetual. Those who cannot remember the past are condemned to repeat it” (p. 284 [85]). As we reinvent inpatient psychiatry for a new generation, it is essential that we remember what has gone before. We need our history – good, bad, and indifferent – in order to continue to grow. Modern psychiatric hospital physicians are engaged in the most traditional work in the history of psychiatry – the care of seriously ill patients within institutions. Like our predecessors more than a century ago, the ability to take care of these patients requires special skills and a comprehensive awareness of psychopathology and tools to manage behavior. As Michael Casher and Joshua Bess illustrate in this book, inpatient psychiatry remains an exciting challenge to modern practitioners at the historically most important site of care: the hospital.

Further Reading

In addition to the citations already provided, interested readers should avail themselves of two outstanding surveys of the history of American psychiatry. Edward Shorter completed an account of psychiatry’s transformation over the last century and a half, focusing on somatic treatments and comparisons with Europe [86]. Historian Gerald Grob, one of the most well respected experts in the history of psychiatry, completed not only a three-volume exploration of American psychiatry (cited in several places above), but also wrote a one-volume overview that is accessible, informative, and provides an ideal introduction to the history of psychiatry [87].

The history of institutional psychiatric care in countries outside the United States is broad and complex. The most prolific author on the topic of British and international psychiatry was the late Roy Porter, whose voluminous works covered the history of madness, the history of British institutions, and surveys of international institutional psychiatry [88, 89, 90].

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