SHORT VERSUS LONG-STAY PSYCHIATRIC HOSPITALIZATION

(Results for Schizophrenic Inpatients)

THESIS

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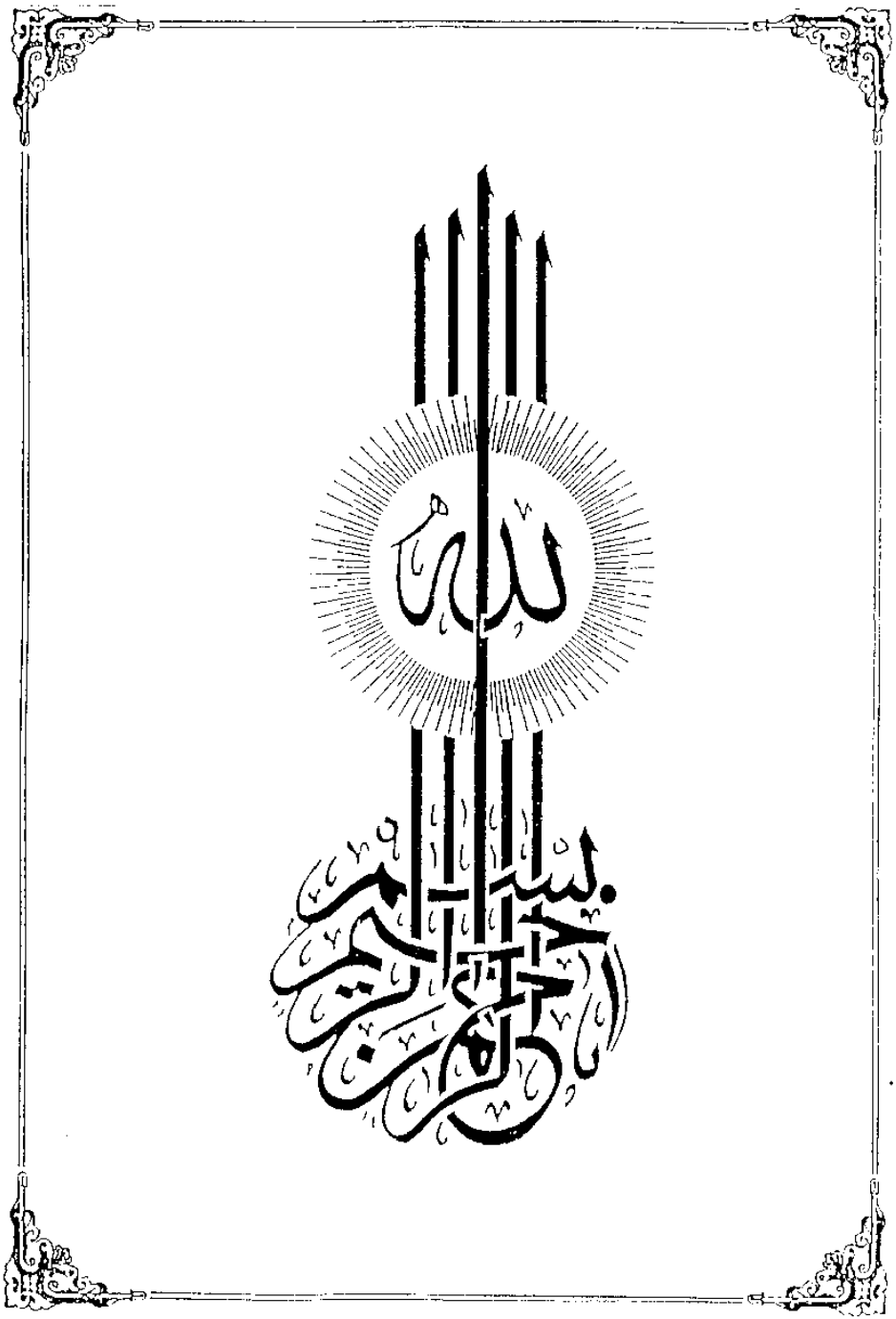

C O N T E N T S

INTRODUCTION

INTRODUCTION

Battles have always been a feature of psychiatry (Tantam 1985). Clinical wisdom and experience dictate that psychiatric hospitalization will be necessary at various times throughout the life course of the schizophrenic patient (Carol 1982).

In recent years there has been a re-evaluation of the role of psychiatric hospitalization as a part of a comprehenisve mental health care delivery system. There has been a trend toward early discharge of the hospitalized patient in order to avoid the potentially deleterious effects of prolonged hospitalization such as regression, damaged self image, deterioration of role functioning, extrusion from the family, and loss of ties to community institutions (Herz 1976). As a result, many psychiatrists have attempted to return the hospitalized patient to the community as early as possible, and to provide psychiatric care within the patient community rather than in large state hospitals (Jeffrey 1979, Herz 1979).

While it appears that for most patients short-term hospitalization is preferable to prolonged hospitalization, there are some patients who need long-term inpatient care such as extremely self destructive patients or patients

who have such disorganized functioning that they need the protection of the hospital in order to participate in a therapeutic program (Stephen 1976, Herz 1980).

Mosher (1983) concluded that there is no need to hospitalization what so ever if available alternatives in the comminaty are possible. Mosher bases this conclusion on the fact that there are treatment for psychiatric disorders which are at least as effective as, and may in some cases be more effective than hospital admissions and at the sametime cost less.

However, Tantam (1985) does not agree with Mosher that it is mere prejudice which stops most psychiatrists from reducing their admission rate.

Has the avoidance of hospitalization produces gains for patient care?. Has the trend toward treatment of patients in the community rather than in the hospital benifited the patients directly?. What has been the effect on the families of patients?Is it true that the cost of treatment for all patients in the community is significantly lower than the cost of hospitalization. These are few questions which may find the suitable answers in the following chapters.

REVIEW OF LITERATURE

I- History of Mental Hospitals

I- In the world:

The idea of caring for people with mental disorders, rather than simply containing them, did not emerge again until the 18th century (Philip 1980) .

Psychology has been left to the philosophers, and the laws of the behavioural sciences has not even thought of. Physicians were confined to the use of physical and chemical remedies that they knew from empirical application in the treatment of other diseases (Philip 1980).

From the dawn of history, until about the middle of the 19th century, the mentally disordered were indiscriminately exorcised, or burnt, or left to wander at will or were chained up and beaten (Patricia 1979).

The discovery of a slide gallery in North saqqara leading into a new complex consisting of a main axial passage from which branched a vast maze of complicated lateral galleries opening off it on either side. These side galleries on an average 3 meters high by 2.5 meters high by 2.5 meters wide wer completly filled with thousands of sealed pottery Jare similar to those found containing wrapped mumified ibises in the galleries some distance to the north discovered in 1964. The Jars, however, proved to contain the mummies of falcons, many

of them most beautifully wrapped. These are probably for worship and treatment of the diseased people in separate rooms, a discovery which may indicate the probability of the first hospital system in the world (Okasha 1978).

During the later part of the 19th century and early 20th century saw large mental hospitals being built some distance away from centres of large cities, sufficiently faraway to keep the mentally sick at a respectable distance from the rest of the community (Maurice 1974).

The satisfactory running of these hospitals used to depend upon the submission of the patient to authority with a minimum of resistance, that is the so called authority-submission formula operated. Repressive control were used, namely, locked door, restraints, segregation of some sexes, heavy sedation, ECT, prolonged sleep and leucotomy. In their places most of these measures were legitimate treatment procedures, but some were frequently used as punitive measures. Patients were threatened with these treatment if they did any thing to disturb the peace or the tidiness of a ward. So there came to exist in patients fear of such treatment, and on top of this, the fear of being moved to a disturbed ward with a resultant loss of privilege from the staff.

The patients tended to blame the nursing staff

entirely [illegible] attitudes, and would not dare to convey their state of oppression to the doctor for fear that further punishment might be inflicted by nursing staff.

The doctors were not blameless, they gave consent to such repressive measures. The patients became more dependent and lost their initiative and loose the sense of responsibility. The final result was that has been termed "institutionalization syndrome" (Martin 1955) or "institutional neurosis" (Russel Barton 1959).

Both the authority - submission formula and the hospital acting as the providing parent, leading to greater dependency in patients, help to produce this state of institutionalization. When the nurses are asked about the progress of an institutionalized patient, the usual reply is ., "He gives no trouble, doctor, he is cooperative". Here" cooperative" usually implies that the patient does as he is told with a minimum of questioning or opposition. This response on the part of the patient is very different from that true cooperation, essential to the success of any treatment in which the patient strive to understand, and work with the doctor and other staff members in efforts to cure (Maurice 1974).

The institution that we today call hospitals are the product of a slow and graduall process of evolution. According to Sigerist (1933), gratuitous or semigratuitous rest houses for poor and weary travelers, evolved by slow degree into places for the

care of the sick, later into centers for clinical instruction and demonstration and most recently into foci of medical research. It is difficult to determine when, in that long process, hospitals began specializing in accordance with the diverse type of known disease. A "madman" of course, was epitome of all evil: he could not be understood, he was mysterious, and threatening, at times physically but always pschologically. May be because he was a reminder to all men of what could happen to any of them under stress or injury. To defend itself against "the mad" society first created institution for purposes other than therapeutic.

The Chinese, Egyptians, Indians, Persians, Greeks, Jews, and above all the Arabs are credited with types of enlightened care, as well as institutions for mentally ill patients (Rubin 1972).

Although the historic beginings of genuine psychiatric hospital treatment are still a matter of controversy, evidence is accumulating that the first authentic psychiatric hospital in the Western World were founded in Spain during the 15th century. This hospital was opened in 1410 by Father Juan Gilabert Jofre and is still in operation (now called the Psychiatric Hospital of Father Jofre) and is the oldest among all the

mental hospitals presenting function in the entire world (Chamberlain 1966). Bethlem Royal Hospital (Bedlam) in London was founded in 1247 and possibly began receiving mental patients around 1377, but Bedlam was not totally converted into a "lunatic asylum" until 1547, and even then in practice it was simply a "mad house". The village of Gheel in Belgium, became the forerunner of community psychiatry, perhaps in the 13th century (Rubin 1972). In 1752 the Pensylvania Hospital became the first medical facility in America to separate a unit for psychiatric patients. Nonetheless, psychiatry in the United State developed outside the mainstream of medicine in association with almshouses, prisons, and orphanages until the middle of the 19th century .

In the first half of the 19th century the influence of Pinel and Tuke began to be felt in this country in the form of moral treatment, such hospitals as the Hortford Retreat, the Worcester State Hospital, and the Bloomingdale Asylum became known as pioneers of the new treatment philosophy. Dorothea Dix carried the new humanism in psychiatric treatment to state legislatures across the nation, from those legislatures emerged

the concept of state government responsibility for the mentally ill and the beginning of the state hospital system. (Eugene 1980).

Phillipe Pinel is viewed as a kind of patron saint of psychiatry for having eliminated use of physical restraints and for introducing enlightened humane reforms at the Biatre and Salpetriere at the end of the 18th century. He was influenced by the scientific social, ideological thinking of his day, also he was aware of the approach to the care and treatment of the mentally ill that had been Practiced in Spain since the 15th century (Lewis L. 1980).
The begining of the 20th century ushered the development in biology, such as the discovery that spirochete causes syphilis, which helped to secure the concept of psychiatric hospital and its relationship to medicine. Insulin shock and ECT in1930's gave further impetus to the notion of a psychiatric hospital as a medical treatment facility. Simultaneously, psychoanalytic ideas were rapidly captivating the immagination of American psychiatry and influencing therapeutic methods in such places as the Meninger Clinic and Chestrut Lodge.