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History and Treatment of Mental Illness in the United States

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History and Treatment of Mental Illness in the United States

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This thesis for honors recognition has been approved for the
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Dedication

To the misunderstood, misguided, and scared; may the time come when knowledge is more powerful than fear.
# TABLE OF CONTENTS

Signature Page.................................................................................................................. 2

Acknowledgements........................................................................................................ 3

Dedication........................................................................................................................... 4

Table of Contents............................................................................................................ 5

Abstract............................................................................................................................. 8

## CHAPTER 1

Introduction....................................................................................................................... 9

Etiology............................................................................................................................... 9

Risk Factors..................................................................................................................... 10

Treatment........................................................................................................................ 10

Social implications.......................................................................................................... 11

Ethical implications........................................................................................................ 12

Financial implications..................................................................................................... 13

Nursing role..................................................................................................................... 13

Purpose of paper............................................................................................................ 14

Praxis theory of suffering............................................................................................... 14

## CHAPTER 2

Review of Literature......................................................................................................... 17

Historical treatment of mental illness from the 1600’s to present.............................. 17

State mental hospitals................................................................................................. 21

Familiar approaches................................................................................................. 21

Scientific approaches................................................................................................. 22
Deinstitutionalization..................................................................................23

Experience and adjustment........................................................................24

Past and Present Views of Social Stigma..................................................25

Treatment Modalities................................................................................27

Psychosurgery..........................................................................................27

History of electroconvulsive therapy.......................................................28

History of pharmacotherapy......................................................................30

History of lithium treatment......................................................................30

History of psychiatric treatment..............................................................31

History of therapeutic milieu.....................................................................31

CHAPTER 3

Methodology..............................................................................................34

Qualitative Method of Historical Research..............................................34

Steps of analysis........................................................................................34

Sampling......................................................................................................35

Data Collection and Procedures...............................................................35

Data Analysis............................................................................................35

Developing themes....................................................................................35

Reliability.....................................................................................................36

CHAPTER 4

Results.......................................................................................................37

Warm Springs............................................................................................37

Related History..........................................................................................38
Abstract

The history of mental illness in the United States includes treatment that has varied from misunderstanding to death. In the past, society has ostracized, tortured, ridiculed, and killed those with mental illness. Even today, social stigma can be devastating not only for the individuals, but also for the family. Treatments have varied, from surgical lobotomy, electroconvulsive shock, pharmacological modalities, to alternative therapies. With each new therapy, and more physiological understanding, there is hope for societal stigma to disappear in the future. The purpose of this thesis was to explore treatments, beliefs, stigmas, and institutionalization at Warm Springs. As nurses, there is a duty to bring awareness to fair treatment, and freedom of choice to the mentally ill.
History and Treatment of Mental Illness in the United States

CHAPTER ONE

Introduction

“Negative perceptions regarding depression and its treatment contribute to the 30,000 suicides committed annually in the United States” (Halter, 2004, Abstract ¶ 1). Depression is classified as a mental illness. The historical stigma and misunderstanding associated with mental illness is remarkable and in many ways still influences society today.

Much of what we live with in the present is a direct result of decisions made in the past. The way in which the past remains active in the present can be seen in the way that current, unhelpful, stereotypes of the mentally unwell and those who work with them can be traced back through time. (Beer, & Ion, 2003, p. 238)

The social implications, stigmas, and treatments for mental illnesses have become more effective with time, but there is still instability and vulnerability in our current state of knowledge concerning mental health problems (Beer, et al., 2003). There are advantages in a historical perspective of the treatment of the mentally ill. “Such an understanding can help us to appreciate how modern attitudes, approaches and responses have changed and evolved over the years and how difficult some of these might be to change” (Beer, et al., 2003, p. 241).

Etiology

“Mental illness, by definition, is a term used to describe all diagnosable mental
disorders” (Boyd, 2005, p. 920). Mental disorders are ailments that are linked with the presence of psychological suffering; destruction in psychological, social or occupational functioning; or a significantly increased risk for death, pain, disability, or an important loss of freedom (Boyd, 2005). There are many categories and subcategories of classifications of mental illness that separate the disorders and define or delineate uniqueness of symptoms, side effects, treatments and risk factors.

*Risk Factors*

“Genetics contributes susceptibility to most psychiatric conditions and the understanding of the genetic factors is increasing rapidly” (Coney, Puskar, & Steele, 2004, Abstract ¶ 1). The path of mental illness is more diverse than previously thought and is influenced by many different factors (Chopra, Katz, Roe, Rudnick, & Wagner, 2004). Many mental illnesses have risk factors including not only genetics, but also gender, age (elderly), poor economical status or situational trauma.

It was believed that mental illness could be caught by social interaction with the mentally ill. This belief lead to the common practice of placing the mentally ill in asylums on the “outskirts of town in order to reduce the likelihood of the mentally disordered passing on what was considered to be their bad stock” (Beer, et al., 2003, p. 238). This attitude resulted in harsh treatments for the mentally ill by a society that was not able to care for them.

*Treatment*

A variety of treatments have been utilized for the care of mental illness. It wasn’t until the Colonial Era (1700-1790) that the United States started to view mental disease and disorders as illnesses to be treated. With this new thought process came techniques
including asylums/hospital placements, bloodletting (old by many standards but new with the use of mental illness), mechanical devices (The Tranquilizer Chair), insulin coma therapy, psychosurgery (lobotomy), electroconvulsive therapy, psychoanalysis, sensations therapy and psychopharmacological therapy (Boyd, 2005).

Many treatments have evolved to either new methods or safer treatments for the patient. Advances in pharmacology alone has produced results that ten years ago were not available. “Understanding the past is a useful way of opening up the possibilities that may exist in the present and the future” (Beer, et al., 2003, p. 239). The hope is that a social understanding is also possible.

Social Implications

“Many people who would benefit from mental health services opt not to pursue them or fail to fully participate once they have begun” (Corrigan, 2004, p. 614). Although reasons are varied and personal, a common factor between individuals is often social stigma. Stigma, defined as being socially discredited or perceived as flawed on a personal characteristic, (Blaine, 2000) has very strong social implications.

People want to evade the label of mental illness and the stigma it brings (Corrigan, 2004). Individuals feel that by being labeled, they are excluded or categorized by society. Many feel a loss of self-esteem, self-awareness, and opportunities within the community (Corrigan, 2004). Mental illness may disrupt normal daily activities, schedules, and lifestyles. Many try to hide their illness from others, pushing themselves inward and feeling more excluded from their community or society as a whole.

Throughout history there has been stigma attached to the mentally ill; the lot of people that society perceived as mentally ill or unstable were ostracized to areas outside
the community, placed in state hospitals, had exorcisms performed, or simply were treated inhumanly (Corrigan, 2004). Even more recently, in the 20\textsuperscript{th} century, people tried to hide their mental illness in order to obtain insurance benefits, a driver’s license, or admission to schools (primary, secondary, college, and graduate levels) (Fink & Tasman, 1992).

\textit{Ethical Implications}

Inhumane, unethical treatment is common throughout the history of mental illness. Many times those viewed as mentally ill were deemed dangerous to society and locked up. Society believed the mentally ill or “insane” were not sensitive to extremes of temperature, were cheap labor due to their weak minds and strong backs, and were often humiliated, tormented, or experimented upon (Boyd, 2005). Unfortunately many treatment methods were direct reflections of the popular beliefs of the times. In many situations, the care provided for the mentally ill was no more than food, clothing and lodging. The facilities were dreadfully dirty, many times heat was not provided, and there was no understanding or effort to help these individuals cope with what was ailing them, or return to society. “The differences in the treatment of mentally ill patients typically depend on the community’s perceived notions and fears of those with mental disorders” (Boyd, 2005, p. 4).

Much of the treatment that is standard today is a work in progress from times past. Many mentally ill are still housed with food, clothing and lodging being the staples, but now the treatment of the person with therapy, or other methods is more common than that of beatings, strangulation, or straightjacket confinement. “Changes in traditional treatment models and a focus on broader societal interventions are needed to facilitate
recovery” (Chopra, et. al., 2004, Abstract ¶ 1) and advance the understanding and treatment of mental illness in the 21st century.

Financial Implications

The financial burden of mental illness is astounding. For many in this day and age, insurance is available for care and medication costs, but it is still much less than the amount that is spent on physical ailments. Many states provide assistance for those that are eligible for treatment, and medication at little to no cost to them. Unfortunately, this low cost system is usually over burdened, and many people that are in need are on waiting lists (Gedrose, 2005). With this, the costs of medications alone are rising and technology is costly.

From a historical stance, many of the first mentally ill patients were provided care through the clergy. Some small communities kept their mentally ill in the community and tried to provide for them. If a person was from a family of wealth, they were shipped away to a private hospital to be taken care of or ‘fixed;’ others were jailed, hung, burned, ostracized from the community or put in state hospitals or asylums to be congregated among others that society perceived unmanageable. In these institutions, uneducated, ill-qualified persons were in charge of caring for the mentally ill.

Nursing Role

The role of the nurse has changed dramatically throughout history. Many times, historically, attendants of the mentally ill were stigmatized almost as much as the people society deemed mentally ill. Nurses originally were attendants to doctors, or worked in state hospitals. The development of mental health nursing was much slower than that of general nursing due to the slow growth in understanding and knowledge of the nature,
causes, and treatment of mental illness (Hart, 1997). Many attribute psychiatric-mental health nursing to Florence Nightingale’s seminal work that emphasized the holistic view of the patient. The body, mind, and soul are inseparable, just as the person is inseparable from the family and community (Boyd, 2005).

Nursing in the 21st century is now guided by standards of care, regulations and guidelines. The constant developments in psychiatric nursing are ever changing.

Conditions have changed in the last twenty-five years. More and more the need is felt for intelligent, cultured men and women, with big sympathies and commonsense, who have been trained in the laws of health of body, mind and soul. Truly, such nursing is the most comprehensive of all nursing, and with the ever-increasing number of the insane and neurotic in which our civilization, by its multitudinous demands… (Sumner, 2001, Abstract ¶ 1)

Purpose of Paper

The purpose of this paper is to bring awareness to historical treatment of the mentally ill and to enforce the need to constantly look for better understanding and treatment of those that are living with mental illness. We as a society need to learn from the pages of history and move forward with the knowledge of our past treatments and mistakes.

Praxis Theory of Suffering

Suffering is perceived as comprising two major behavioral conditions: enduring and emotional suffering. Enduring consists of emotions being suppressed and manifested as an emotionless state. Emotional suffering is an unconcealed state of severe
anguish where emotions are released. People who are suffering move between these two states (Morse, 2001).

Mental illness has been perceived as a fad, a theory, and a metaphor. Many times society believes that mental illness is an excuse for those who are weak, lazy or unable to deal with the expectations of society (Edgerton & Plog, 1969). People with mental illness have been stigmatized throughout history and in society today. The mentally ill person may experience denial, distortion, projection, avoidance and regression during times of heightened emotion, treatment or stigmatism (Barry, 1998).

The suffering that the mentally ill person endures can be a lifelong process. Historically society has scorned, banished or ignored the mentally ill. The intolerance by the larger society has caused physical pain, torture, and many times death. If treatments were not available, the mentally ill would be locked inside themselves, not being able to take care of their basic needs. They may be a threat to themselves, the ones they love and society as a whole.

Medicine has been slow to recognize that suffering goes beyond just the physical. The mentally ill will move between the states of enduring and emotional suffering in an attempt to simply cope. Many times it can be seen that enduring takes the form of denial and emotional suffering takes the form of negative reactions to stigma, drama, and self-defeating actions. The mentally ill person may have both physical and psychological pain. They may not understand what is happening, and they may not be aware that their suffering is affecting others.

The nurse is the caregiver for those that suffer. Historically the role of the nurse has changed and now incorporates not only assisting with the basic needs, but also acting
as an advocate for those that have been stigmatized for so long. As the past molds the future, there is a need for the care and protection of those that are mentally ill, or those that cannot protect themselves. The praxis theory of suffering embraces the depth and variability in those that suffer and helps to bridge the gap of misunderstanding. This theory was chosen on the basis of the historical suffering of people with mental illness, and the ineffective methods that society chose to implement when dealing with the manifested problems of the mentally ill.
CHAPTER TWO

Review of Literature

The suffering of the mentally ill has occurred and is chronicled throughout history. Centuries of stigmatization, abuse, neglect, and misunderstanding of the mentally ill can be found throughout the historical literature of the United States, beginning as far back as the Colonial Era. History has had images of bodily health, mental health and ill health closely entwined, with appearance and status playing a role in determining who is sick and who is well (Davies, 2001).

*Historical Treatment of Mental Illness from the 1600’s to Present*

The late 1600’s were a time of growth, mystery and superstition. Mental illness was not understood nor did it have a name, let alone a definition. Many times people that did not fit into the structures of society: the eccentric, the confused, the lost or person’s displaying “suspiciously queer behavior” (Deutsch, 1949, p. 20) were ignored, ostracized, locked away or persecuted. From the very beginning, the United States and the people that filled her shores were identified through religion. These varied and intense religious beliefs held that all man’s suffering and healing was in the hands of God. Many times demon possession, Lucifer’s influence or witchcraft were the common explanation for most forms of mental illness. Saving the soul took many forms of treatment including bleeding, dunking in bodies of water to “cleanse” the soul, beatings, the rack, the gallows, stoning, and burning at the stake (Deutsch, 1949).

The thinking of the time was that these punishments would rid the body, mind and soul of the evils that had taken them. By bleeding the person, the evil would flow from the body; beatings, racking and stoning were ways to help the person come back to their
right mind and drive out the evil (Deutsch, 1949). If herbal remedies (St. John’s Wort), prayer and dunking did not cause the evil to be gone, the person could be labeled as a witch and burned at the stake. “The records of witch trials that have come down to us offer convincing evidence that a large percentage of those accused and convicted of witchcraft were really insane” (Deutsch, 1949, p. 20).

Torture was not simply for those deemed possessed, but many that were suffering from some form of insanity. Many times, if the mentally ill were not burned or tortured to death, they would be put out by the community to roam the country sides and forage for themselves. “Frequently, the mentally ill were permitted to wander from place to place, or were hurriedly “passed on” by callous authorities in fear of their “falling on the town”” (Deutsch, 1949, p. 45). Many were paupers, beggars, and street urchins locked inside themselves, and ignored by a society that did not want them.

The 1700’s were weighed down by the same superstitions and attitudes that plagued the previous century. Many of the treatments like bleeding were done “freely and often” (Deutsch, 1949, p. 28). Mental diseases were treated as medical difficulties and attributed to the climate, the lunar cycle, faith and the harvest. If any type of mental illness was recognized by the community, it usually was for the purpose of punishing, setting an example or repressing the individual and others. The harmless were treated as street people or jailed by the community to contain the evil. The persons labeled as violent were treated as common criminals, shackled and kept away from society (Boyd, 2005).

Almshouses, houses of corrections and workhouses all sprang up in the early 1700’s (in more populated cities). These establishments were modeled from institutions
in the United Kingdom. They were used to house the poor, the criminal and the mentally ill. There was no distinction of treatment, and many times they were chained, confined and treated like sub-humans (Deutsch, 1949). From the growth of the workhouses and the houses of correction came the house for the lunatic.

In the late 1700’s and early 1800’s, state hospitals and asylums for the mentally ill and the sick were established. Benjamin Franklin established Pennsylvania Hospital to “receive those with mental disorders for treatment and cure” (Boyd, 2005, p. 5). Many times in the hospitals, the mentally ill patients were housed in the basement, or on the lowest floor. Hospitals did not offer more than food, clothing, and shelter. Patients were stigmatized by society, hid away, and dealt with like caged animals or as an embarrassment. Many asylums, called lunatic asylums, and hospitals were worse than the workhouses and prisons. Many of these establishments, whether it be the hospital or the asylum, had small windows that did not allow light in, chains in the rooms, and “Madd-shirts” or straight jackets were utilized to contain the ill patient. Violence was used to control the ill patient and many believe that torture and experiments were done on the mentally ill.

Through the years, treatments for mental illness, some of them now regarded as barbaric, were tried on patients. “Remains of hydrotherapy tubs indicate that mental patients were submerged for hours in long baths, sometimes in hot or cold water, in a treatment that was popular in the late 1800s. It might involve applying ice caps on their heads or bandages wrapped around their eyes and ears to shut out other sensations. (Ackerman, 2003, ¶ 46)
By the late 1800’s and early 1900’s, conditions within the walls of establishments that housed the mentally ill were starting to be regulated, the chains were removed, and the same society that shunned the mentally ill now would not stand for the ill treatment of them (Ahmed, & Plog, 1976). The primary care of the mentally ill was the responsibility of individual states, and the patients received custodial care, but not treatment, or curative measures. The patients were protected, and watched to ensure safety for themselves, the other patients and the staff (Dowdall, 1999).

Although the movement and growth of knowledge was beginning to look upon mental diseases as a treatable illness instead of a medical condition, fear was still at the heart of the society. The continuing belief that mental illness could be communicably caused, continued the placement of many of these establishment on the outskirts of towns. Society and polite gentile people did not want to deal with the suffering of the mentally ill. In many ways, the treatment of the times was based on European influence, and the knowledge of the day (Grob, 1983).

The treatment and care of the mentally ill was fueled by misunderstanding, fear and confusion. Many people suffered due to the lack of proper treatment and the stigma that society held for the less fortunate. Some of the mentally ill were put on display like a carnival side show for the entertainment of society and to observe the torture of “baiting the madmen” (Deutsch, 1949, p. 64).

The growth and industrialization of the United States was reflected in the genius that produced alternative therapy. Many forms of treatment included man-made contraptions like that of the tranquilizer chair made by Benjamin Rush. Patients would be strapped into various designs of chairs, completely immobilizing every part of the body
for periods as long as six months. The patient’s sight would be blocked with a wooden shroud, immobilizing the head while they were doused with ice-cold water, or bled (Ackerman, 2003). According to Rush, “insanity was caused by morbid qualities in the blood” (Ackerman, 2003, ¶ 13). Rush also believed that insanity could be drawn out by strapping patients horizontally to a board and spinning them around at great speeds (Ackerman, 2003).

Along with the movement of “alternative therapy,” hospitals and asylums were enlarged to be able to meet the demands of patients and to also separate the men and the women from each other and the general population from the mentally ill.

State Mental Hospitals

There is a separate and unique culture within the mental hospital. “The mental hospital as an object of study and humanitarian concern has been and can be viewed from several different perspectives” (Dunham & Weinberg, 1960, p. 5-6). These perspectives help to differentiate and focus attention on particular aspects of the mental hospital. Some have been classified as familiar and scientific. The familiar approaches are the administrative, “Pollyanna,” and muckraking. The scientific ones are psychiatric and social psychological approaches.

Familiar approaches. The administrative approach emphasizes the hierarchical structure within the mental institution providing specific functions of providing custodial care to patients. The driving force behind this approach is cost, number of patients, types of facilities used, and the management of the state property. In this setting, the patient is mainly viewed as a worker, to sustain the whole of the facility, instead of a patient in which to heal.
The Pollyanna approach visualizes the mental hospital as an ideal institution. This approach embraces having an attractive, impressive and nice hospital area that will impress the families, and community. Bad things cannot happen in such a nice facility, and this attitude promotes confidence in the families that the institution and personnel are striving to give the best care available (Dunham & Weinberg, 1960).

The opposite of the ‘Pollyanna’ approach is that of the muckraking approach. This attitude stresses the reality or the undesirable features of the state hospital setting with the “intention of securing correction and improvements” (Dunham & Weinberg, 1960, p. 7). This approach is the more common societal view, or wider public view than any of the others. Many writers and Hollywood directors have played up on this by exaggerating the undesirable features, and not looking to see the transition and growth of the institutional culture. A very good example of this would be the movie, One Flew Over the Cuckoo’s Nest.

Scientific approaches. The psychiatric approach within a mental hospital is the most widely used and commonly acknowledged among professionals. It is believed to be the only perspective for the study and wellbeing of patients in an institution. This approach is ultimately the role of the psychiatrist and the patient, the analysis, and the symptoms. With this approach, the mental hospital is the comprehensive approach, allowing the mentally ill to be individually diagnosed, and the proper therapy prescribed. The down side of this is that the psychiatric approach enforces the belief that the institutionalization is a result of the patient having personal disorganization, or personality disturbances that affect the mental health, and well being. The group culture, either inside or outside is never taken into consideration.
In contrast to the psychiatric approach, social psychology regards the hospital setting as a time to work on the growth of the personal relationship. Patients are regarded as individual people who can participate socially to some degree, and that the mental illness only affects segments of their social personality (Dunham & Weinberg, 1960). This approach simply means that the mental condition and the hospital situation are viewed as separate by the patient, and staff. This allows for open growth both within the facility and in social settings.

By the mid 1950’s, the stoic and grand mental hospital with wards and confinement were being downsized to community care facilities with cottages and campuses (Lampton, 2000) that had a less hospitalized feel to them. Mental health care and treatment had shifted from the single institution to multiple sites within the community (Davies, 2001), the deinstitutionalization era had begun.

Deinstitutionalization

Deinstitutionalization idealistically was portrayed by advocates, consumers, and society as a liberating and humane alternative to the restrictive care provided within the state mental institution (Dowdall, 1999). It was the result of many health care reforms that looked at the need and cost of large state funded institutions. It is often attributed to the decreased need for permanent care when the advances in pharmacotherapy were realized and utilized. Ideally, it represented a more liberal and humane way to treat people that were struggling with mental illness. It also was a landmark for the adjustment from inpatient, long-term, custodial care to the short-term outpatient care that the community would provide.
The movement of deinstitutionalization was prominent in the 1950’s and 1960’s. This was due to many factors, including the founding of the National Institutes of Mental Health (NIMH). This alone, gave the patients a voice, and helped to pass future laws that gave the patients back their rights. After the founding, there was a lot of research on pharmacotherapy, and medications were developed and introduced into state hospitals beginning in 1955. With these medications, there was new hope for patients. The medications helped address some of the symptoms of mental disorders, and worked very well for a certain percentage of people that were previously institutionalized (Dowdall, 1999).

In 1963, President John F. Kennedy signed a mental health bill, Community Mental Health Centers Act, which accelerated the deinstitutionalization trend, by introducing a framework for community health care centers. The idea was to get the patients back into the community for care, by utilizing the new pharmacotherapy treatments, and putting them back into social settings. Many experts believed that there was “a high potential for normalization through active involvement in community life” (Ahmed & Plog, 1976, p. 5). In many cases, the patients were able to go back home, or be closer to family.

*Experience and adjustment.* Since many of the patients had been long time residents of the state mental institutions, there was an adjustment period for patients, families and society alike. Many of the patients that were transferred to community based facilities were not able to go into a family environment. Some ended up in skilled nursing facilities (nursing homes), board-and-care facilities, out of state hospitals, shelters or they became homeless.
“The major issue in deinstitutionalization has not been the relocation to similar facilities but whether communities can readily absorb the patients” (Ahmed & Plog, 1976, p. 5). The concern was whether local communities would be able to adequately meet the needs of the patients, or provide the adequate support for the patient. Since one push for deinstitutionalization was from the outcry of society for the humane treatment of the mentally ill, it created quite a conundrum. The same society that stigmatized, and locked away the mentally ill, was now trying to figure out how to embrace a large number of individuals that were back in the community (Dowdall, 1999).

In various studies about the effects of this on both the patient and the community, it was unanimously found that neither the patient nor the communities were dealing with it well. “The mentally ill are regarded with more distaste and less sympathy than virtually any other disabled group in our society” (Ahmed & Plog, 1976, p. 34). The public rejection was as strong now, as in many other times through out history. “A major portion of the population continues to be frightened and repelled by the notion of mental illness” (Ahmed & Plog, 1976, p. 35). It was projected that the efforts to improve the quality of care among the mentally ill by providing community based care, would actually backfire and create more problems for the patients, and their families. “The community was less than overjoyed to have the severely ill and the chronically ill in its midst “Ahmed & Plog, 1976, p. 36).

*Past and Present Views of Social Stigma*

As shown in the above text, negative societal views of the mentally ill have developed over the years. “Clearly the unhelpful stereo-types that we encounter in the present have their roots in the past” (Beer, & Ion, 2003, p. 238). Controlled social
laboratory studies have shown an inverse relationship between public stigmatization, care seeking, and treatment adherence. Stereotypes, prejudice and discrimination continue to dominate society’s perception (Corrigan, 2004). Basic misunderstanding or lack of knowledge has contributed to the labeling of the mentally ill: lunatics, crazies, mad-men, attention seekers, whackos, screw balls, etc.

The mentally ill individual is forced to continue a public façade to avoid and escape public stigma and labeling. Many times self-stigma is placed because of the societal belief that if a mental disorder occurs, then the intelligence and integrity of the person is somehow flawed (Corrigan, 2004). “Stigma yields two kinds of harm that may impede treatment participation: it diminishes self-esteem and robs people of social opportunities” (Corrigan, 2004, p. 614).

With history showing that society’s treatment of the mentally ill has been less than desirable, we now need to learn from that and move forward. There is ample evidence that access to effective interventions in society and community settings still remains a barrier. As an advocate for the mentally ill, the nurse needs to embrace the individualism of each person and help both the patient and society to understand the gifts, strengths, and beauty of each human. The nurse who has been trained in the “laws of the body, mind and soul” are the most comprehensive advocates for the mentally ill that our society is “leaving in their wake” (Sumner, 2001, Abstract ¶ 1). Interventions that focus primarily on improving the individual’s functioning and quality of life and educating the public should be a priority over curing the illness, or treating patients like a sub-human (Drake, et. al., 2003).
Treatment Modalities

Treatment with hydrotherapy, wet packs, and prolonged warm baths for sedation, electroshock therapy, chemical shock, pharmacology and psychosurgery had all become ways to treat mental illness in the 1800 and 1900’s (Lampton, 2000). Many of these were performed to change the behavior of the patient, by physical or chemical means.

Psychosurgery. Psychosurgery was the movement in the early to mid 1900’s that utilized the surgical alteration of brain matter. This is also referred to as a lobotomy, frontal lobotomy, or transorbital lobotomy. The use of lobotomies for treating mental ailments dates back as far as the twelfth century, so the “idea of drilling holes into the brains of the mentally ill to cure them was not, in the 1930’s, new to psychiatry” (Whitaker, 2002, p. 111). Up until this time, insulin coma, metrazol and electroshock had all appeared within psychiatric medicine, and especially asylum or mental hospital medicine. They all altered brain function, but there was no precise control over any region of the brain. This was where a frontal lobe lobotomy came into play (Whitaker, 2002).

The practice of this procedure as a cure for the mentally ill was not really new, but the drilling and then scraping or killing of the white matter (with absolute alcohol) within the brain for mood and intelligence manipulation was. This became a hallmark for the treatment of hospitalized patients, and with some success, was hailed as “psychiatry’s crowning achievement” (Whitaker, 2002, p. 107). “Severing the connections between the thinking brain and the feeling brain, it was claimed, produces individuals whose emotional reactions are less intellectualized and whose intellectual reactions are less emotionalized” (Valenstien, 1986, p. 170).
Although thousands of lobotomies were performed in the United States, many were performed on the hospitalized patient, and it was more of an experiment than a procedure. According to Whitaker (2002), research has shown both the positive and negative effects of the procedure through history.

The fuller view of the effects of lobotomy can be found today, in the 1950’s book, Psychosurgery, which is a detailed account of ten years of physician performed lobotomies. Even at the highest stage of recovery, lobotomized patients could not be expected to provide advice of any merit. Those who had been artists or musicians before becoming ill would never regain much interest in such pursuits. They might play the piano a while in a mechanical way, but the “emotional exhilaration” that comes from playing would be absent, and eventually they would stop playing altogether. Those who had inventive imaginations before surgery would become “dull and uninspired.” Nor in their lobotomized state could they experience spiritual yearnings, or any desire to know God. (Whitaker, 2002, p. 126)

Psychosurgery became looked upon by society as less favorable in the mid 1950’s when pharmacotherapy became available (Valenstein, 1986).

*History of electroconvulsive therapy (ECT).* Electroconvulsive therapy is one of the oldest treatments still safely available today; it was formerly introduced in Europe in 1938 and came to the United States within the next ten years (Boyd, 2005). ECT is effective in pregnant women, children, adults, and the elderly. ECT was used commonly for the treatment of mental illness, specifically depression, bi-polar and schizophrenia.
In the 1940's and 1950's, mental hospitals around the country began using electroshock therapy to dull the intellects of the patients and quiet the wards of mental hospitals (Ackerman, 2003). The treatment process for each person varies in length and treatments needed. As a result of pharmacologic advances, the popularity of ECT is waning; pharmacologic agents are used after the treatment(s) have been completed.

“Research continues regarding the safest and most effective methods for administration” (Gomez, 2004, p. 482). A longitudinal follow up study of 46 persons with uni-polar disorder and 12 persons with bi-polar disorder showed that after two years the outcome was better for the persons that were treated with ECT. Out of this group, 93% percent maintained health when compared with 52% of persons that only took antidepressants. In conclusion, the study indicated that chronically depressed persons that have had success on ECT should continue ECT with the combination of antidepressants to prevent relapse (Gomez, 2004).

By the mid 1900's, the technology and knowledge base about mental illness had expanded and society was trying to embrace and treat mental illness as something besides a medical condition. The research on pharmaceuticals alone, especially in the mid 1950's, the use of lithium, and the miracle drug chlorpromazine, cracked the treatment of mental illness wide open. “Previous pharmacological treatments consisted of non-specific agents that sedated patients” (Drake, Green, Mueser, & Goldman, 2003, p. 430) and reduced agitation but they did not relieve symptoms or treat the illness. With chlorpromazine, untreatable patients were released from their restraints, discharged from mental hospitals, re-entered the community and led healthy lives.
**History of pharmacotherapy.** The early part of the 20th century, as mentioned in the above text, saw the use of somatic therapies, insulin shock, ECT, ice baths, and psychosurgeries. Prior to 1950, sedatives and amphetamines were the only significant medications available to alter brain chemistry. Even with these, the effects were limited. It was not until the development of psychopharmacology, that there was any significance advancements, in treatment of individuals suffering from mental illness. This research and discovery changed the structure of psychiatry, and how mentally ill patients were treated (Townsend, 2006).

Chlorpromazine was synthesized in 1950 by a French pharmaceutical company. It was found to sharply limit loco-motor activity in animals, and would put the human patient into a “hibernation” or “vegetative type” state (Whitaker, 2002). Many physicians believed that it could be the pharmaceutical replacement for psychosurgery. “It has a remarkable property of inhibiting lower functional centers of the central nervous system without significantly impairing the function of the cortex” (Whitaker, 2002, p. 145). It brought a portion of the mentally ill population some relief, and freedom from hospitalization, institutionalization, and inhumane treatments.

**History of lithium treatment.** Lithium originally was a treatment for gout, uric acid diathesis, headaches and depression. Lithium has been a pharmaceutical for the treatment of bi-polar and uni-polar mental illness for over fifty years. It has been proven successful for treatment of mental illness over a prolonged period of time. Lithium has been found to “be effective as a continuation treatment following ECT” (Coppen, 1999, p. 3).

Research has been done to investigate the morbidity for a designated time with patients that were not taking Lithium (a placebo-control group) and patients that were
taking Lithium. The research results reported that on average of a two year period of treatment, 62% of the patients taking Lithium were statistically rated as having no mortality where as there was a 3% mortality from the placebo-control group. Evidence, from follow-up studies, has found that 11,085 patients maintained on lithium had 1.3 suicides per 1000 patient years as compared to 24,224 patients not receiving maintenance treatment who had 5.5 suicides per 1000 patient years (Coppen, 1999).

*History of Psychiatric Treatment*

Psychiatric therapy is comprised of many elements, or therapeutic modalities. There are traditional ‘talk therapies,’ also know as active therapy. Art, music, and bio-rhythm therapies are another approach, and group, family and interactive therapies are also successful modalities. Many alternative medical therapies have been included in the treatment of patients to build awareness for how they are feeling, and to provide tools for them to utilize when in a social setting. Another modality, and the one that has been said to be “a fairly recent innovation in psychiatry” (Campbell, 1979, p. 1985) is the therapeutic community, or therapeutic milieu.

*History of therapeutic milieu.* The therapeutic community started as a post World War II psychiatric therapy to work with “demoralized soldiers who were suffering from battle fatigue” (Campbell, 1979, p. 1985). The ideology behind this movement was to get soldiers together in groups and teach them about their illness, and to try to let them relate to each other. A social model of therapeutic community was created which allowed and encouraged free communication, a lessoning of hierarchical interactions between patient and doctor, and reduced the distance between the doctor and the patient, allowing the doctor to be more personally involved in the therapy and empower the patient.
enhance their self-esteem, (d) to promote socialization and (e) to provide opportunities to be part of unit management.

Important components within any therapeutic modality are the concepts of boundaries, safety, and trust. Boundaries help define the functions and responsibilities of both the group and the patient. They are determined to be able to enhance the safety of the milieu setting, by reinforcing the responsibilities and roles within the group (Fortinash, Holoday-Worret, 2004). To feel safe, “clients need to know what is expected of them in their roles as clients” (Fortinash, Holoday-Worret, 2004, p. 442). Trust builds from the concepts of boundaries and safety, and through consistent actions and words that have been developed and stated. These can be either for the client or the group.
CHAPTER 3

Methodology

The purpose of obtaining knowledge about the history and treatment of mental illness in the United States was to discover and analyze the evolution of mental illness, diagnosis, treatments, and stigmas. Historical data shows trends of diagnosis, and treatment that is significant to how society reacts to mental illness in this century. This compiled thesis is a qualitative research project that focuses on the past traumas, treatments, stigma and historical events that have created a web of misunderstanding for the patient, the family and society as a whole.

**Qualitative Method of Historical Research**

The choice of the research design depends specifically on the purpose of the study, and the topic area (Lemone, 1991). Qualitative research is rooted in the discovery of knowledge and understanding of the descriptions and meanings from social experience.

Historical research methodically examines and critically evaluates information and data related to past events (Fain, 2004). Many times it will reveal new ideas, thought processes, or procedures based on the failed attempts of those previously. Researchers that use any historical analysis method believe that if we are not familiar with the events of the past, then the mistakes of the past tend to repeat themselves in the future (Fain, 2004). Its purpose is not to simply review the historical literature, but evaluate present events through analysis of cause, effects, and trends of historical events (Fain, 2004).

*Steps of analysis.* The historical record contains information about events and personalities of great practical importance. As a result, the data can have an incredible
importance for those researchers wishing to deal with significant issues, problems and trends (Simonton, 2001). The steps of this process involve extensive research and reviewing of pertinent and reputable documents in the collection of the references and bibliography (Tompkins, 2005). Articles of a primary medical nature need to be collected, reviewed and determined as reputable sources. A collection of books that place this information in an overall historical context is carried out, such as the review of encyclopedias and complications of cornerstone events (McCoy, 1974).

Sampling

Sampling of biographies, peer-reviewed journal articles, hospital records and photographs facilitated this research. An interview with a nurse at a state run hospital, and discussions with other employees at the facility provided credible information on the history, and current treatment philosophies for the mentally ill.

Data Collection and Procedures

State hospital records were consulted in a review of literature including the treatment and diagnosis of patients. The majority of the research material and data collection came from books and journals that had relevant information to mental illness or health in the United States. The journals were nursing, psychiatric, or psychological in nature, including archival information.

Data Analysis

Developing themes. A review of literature, typical of the research process, provides insight into the possible development of a thematic code (Boyatzis, 1998). Themes used by other researchers regarding their findings create a direct approach in creating new or revised themes from historical data (Boyatzis, 1998). Themes should
capture the qualitative richness of the phenomenon and include five elements: a label, a
definition of what the chosen theme is, a description of how to recognize the theme, a
description of the experience with limitations and exclusions that identifies and qualifies
the theme (Boyatzis, 1998).

Reliability. There are many questions in the literature about the reliability and
validity of qualitative methods of research (Lemone, 1991). The analysis of the data to
show validity is essential to be able to build themes. “This rests on evaluation of all
research tools, some more reliable than others, but tentative conclusions can be drawn”
(Tompkins, 2005, p. 88). As indicated by the themes pulled from the historical overview
of mental illness and treatment, the stigma, suffering and misunderstanding is present in
text, artwork, and methods of the last four hundred years. This deserves further
evaluation and discussion to be able to comprehend where social views were historically,
and where they are going in the future.
CHAPTER FOUR

Results

Warm Springs

Montana State Hospital, Warm Springs, has a long and colorful history. The hospital’s founding as an ‘institution for the insane,” dates back to 1877, when the two founders, Dr. A. H. Mitchell and Dr. Charles F. Mussigbrod, “entered into a contract with the Federal Government and the Territory of Montana to care for the ‘insane’ at the Territory of Warm Springs” (Warm Springs State Hospital Staff, 1977, p. 1). When the hospital opened, it housed thirteen patients at a federal rate of one dollar a day per patient.

The number of patients that were eligible for care, in the State of Montana, increased rapidly at Warm Springs. Many people within the territory that were homeless, jobless, or didn’t speak English were put at the hospital for the officials of the territory did not know what else to do with them. As the numbers of residents increased, the hospital increased in size to be able to house this new demand, purchasing surrounding lands so the institution could be self sustaining. “The able-bodied and harmless patients worked on the farm, at the dairy, in the gardens, laundry, and other parts of the institution” (Warm Springs State Hospital Staff, 1977, p. 1).

After thirty five years of being owned and operated as a private institution, in 1912, Montana State Hospital for the Insane became a state owned, funded, and operated institution. The public, by general election, authorized the issuance of state bonds to cover the purchasing of land, property, and hospital buildings. At the time of the sale, 824
patients lived at the institution, and the estimated cost per day was between .50 and .80 cents. In the year 2005, the average daily cost of a resident is $321.00.

One of the movements for the public to vote for the purchase of the institution was the inadequacy of the previously contracted services within the towns and small communities in the state. The public believed that people with mental disabilities were being victimized, and treated inhumanely. With this public cry for humane treatment, the public also became concerned with the rapid growth of the hospital, and the quality of care that may or may not be provided.

The reality was that the institution did indeed continue to expand to meet the needs of the “insane” and the infirm. The State of Montana also needed a location to provide care for the tuberculosis (miner’s consumption) patients, and the inebriates (those dying of complications from extreme alcohol use) of the state (Committee of Montana State Hospital, 1991). The citizens of the territory and then the state of Montana, felt that there was significant over crowding, and the state was not meeting the needs of the patients, and it was a moral obligation to provide humane care and a suitable institution to house and care for the mentally ill.

Related History

Montana state hospital and tuberculosis. Montana, like many other states, had a large population infected with Tuberculosis. Many times, stigma was associated with this disease and a public outcry led to the state’s first sanitarium for tuberculosis patients. These people were housed in dormitory settings, taking them out of the general public, and away from a society that was both fearful and concerned.
Tuberculosis, by nature is a highly contagious, potentially deadly disease that grew alarmingly with the poor sanitation, and over crowding of many populated towns, and cities (Staudohar, 1997). "It was the leading cause of death in the nineteenth century, and was indiscriminate, claiming the lives of rich and poor, young and old, and country as well as city dweller" (Staudohar, 1997, p. 50).

Tuberculosis has many ways to be transmitted; it can be transmitted by droplets that land on the floor or a surface and are "harbored in the dust particles" that then are breathed in. They can be transmitted by coughing, wheezing, or spitting. Unventilated rooms without sunlight can harbor the disease for prolonged periods, however, the most common cause of tubercular infection is the close and constant contact with a tuberculosis patient. Even the ingestion of contaminated cow's milk can cause tuberculosis of the bones, joints, and lymph nodes (a related organism infects cattle and can be transferred through the milk) (Staudohar, 1997).

Many overcrowded areas in Montana were mining communities, where shanty towns, prostitution, unsanitary conditions, and poor health were common. The crowded, warm, unventilated, sunless and wet environments of underground mines were a great medium for the disease to be insidiously spread. The coughing, wheezing, spitting, and talking of one infected person in these conditions created a close, person to person contact that contaminated droplets could be breathed in by everyone in that shaft. This was a phenomenon that helped create public awareness, and a taboo among miners to discuss symptoms, or seek treatment.

With the death toll of Tuberculosis on the rise, and the infection rate also increasing, the state recognized that something needed to done. "In 1901, the Montana
legislature passed House Bill 104 to establish the Montana State Board of Health. Specifically, the board was to make inquiries and investigations of disease and their causes” (Staudohar, 1997, p. 52). Many laws were passed in the years following, mandating disclosure of infection, by both the public and physicians. These laws ignited the public’s demand for inpatient facilities that could care and isolate these tuberculosis patients.

In 1912, with the state purchase of Warm Springs, the Montana State Tuberculosis Sanatorium was created. With some of the land that Warm Springs incorporated, another hospital was built, and was named Galen. Galen was under the control of Montana State Hospital, and worked closely with both the hospital and the surrounding communities. From 1913, the “staff and facilities at Galen attempted to meet the hopes and needs of the sick and assuage the fears of the healthy” (Staudohar, 1997, p. 57). The treatment imposed a strict regimen for sanitary living, medical care, and treatment. Galen acted as the state tuberculosis hospital until the decline in the disease in the 1960’s, when the facility started treating other lung inflictions, alcohol and chemical dependency.

Historical Achievements of Warm Springs, Montana State Hospital

The institution of Warm Springs has had many achievements, and credits in its one hundred and thirty six years. Within the early years at the institution, the hospital had recognized attributes to humane care and had removed the iron shackles that were common in the 1800’s, both in the penal system and institutions. The removal of the shackles was a giant movement forward. It occurred before the mid to late 1800’s, public
health reform, led by Dorothea Dix, and significantly influenced the standard operations of State and Federally funded institutions (Dix, 1975).

The hospital was created, specifically for the treatment of those individuals with mental illness, or the “insane.” For many years, Warm Springs remained a model psychiatric institution within the United States. Along with this, it was one of the only non-university affiliated hospitals in the United States, which provided treatment of mental illness. In 1924, Warm Springs was recognized as the “first state-supported psychiatric hospital, other than university hospitals, to be recommended for placement on the list of “standardized” hospitals of the American College of Surgeons” (Warm Springs State Hospital Staff, 1977, p. 2). Many other institutions and State Hospitals, especially those founded on the Eastern seaboard, had medical/university affiliations, with the primary care being provided by medical students.

The rapid growth continued throughout the early nineteen hundreds. In 1924, the hospital had 1364 patients, and 134 employees. Of these patients, only 10% were reported as having been born in Montana, and almost half of the population was “foreign born.” In 1938, the patient population had grown to nearly 1900 patients, with a staff of 175. The care at the hospital now included “all public charges afflicted with different mental ailments, as the insane, the aberrated epileptics, imbeciles, idiots, morons, criminal insane, and alcoholic and narcotic addicts” (History of Montana State Hospital, 1991, p. 3).

Ten years later, in 1947, Montana legislation passed a bill and Warm Springs became the center for the Department of Mental Hygiene. With this bill, the legislation also recognized the need for more care within the rural setting. Comprehensive treatment
clinics, or satellite Mental Hygiene Clinics were created within the communities of Butte, Missoula, Great Falls, and Glasgow. They were modeled after the treatment modalities of the hospital, and supervised by the superintendent of Montana State Hospital.

In 1953, Montana State Hospital had nearly two thousand patients residing there (1,980 patients according to historical record, see table 1). This is significant because it is the largest patient count in the history of the hospital, and this surge in patients was directly followed by a nation wide movement to change the face of mental illness and the treatment modalities. In the 1950’s, with the movement of pharmacotherapy and deinstitutionalization, Warm Springs State Hospital was one of the first institutions to utilize modern chemical therapy. It was also used as a research site for the new drugs that were being utilized for the treatment of mental disorders, and illnesses during the years of 1956 and 1957. “Montana State Hospital was one of twelve hospitals in the United States that was given permission to use Phenothiazine” (Beausoleil, personal communication, 2005) during this period. The patient recovery ratio, at Montana State Hospital, was the highest in the nation (Warm Springs State Hospital Staff, 1977).
Table 1

Patients at The Warm Springs Institution.

<table>
<thead>
<tr>
<th>Period of Time</th>
<th>Average Daily Census</th>
<th>Admissions</th>
<th>Releases</th>
<th>Year-end Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1900</td>
<td>147</td>
<td>145</td>
<td>479</td>
<td></td>
</tr>
<tr>
<td>1912</td>
<td>824</td>
<td>316</td>
<td>253</td>
<td>854</td>
</tr>
<tr>
<td>1918</td>
<td>1178</td>
<td>590</td>
<td>469</td>
<td>1212</td>
</tr>
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<td>1929</td>
<td>1518</td>
<td>402</td>
<td>409</td>
<td>1519</td>
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<td>1941</td>
<td>1932</td>
<td>430</td>
<td>395</td>
<td>1926</td>
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<tr>
<td>1945</td>
<td>1879</td>
<td>367</td>
<td>379</td>
<td>1864</td>
</tr>
<tr>
<td>1955</td>
<td>1936</td>
<td>1366</td>
<td>1409</td>
<td>1911</td>
</tr>
<tr>
<td>1965</td>
<td>1521</td>
<td>1297</td>
<td>1181</td>
<td>1407</td>
</tr>
<tr>
<td>1975</td>
<td>885</td>
<td>1707</td>
<td>1867</td>
<td>746</td>
</tr>
<tr>
<td>1995</td>
<td>157</td>
<td>336</td>
<td>487</td>
<td>134</td>
</tr>
<tr>
<td>2005</td>
<td>195</td>
<td>768</td>
<td>937</td>
<td>193</td>
</tr>
</tbody>
</table>

(Warm Springs State Hospital Staff, 1977, p. 6)

Housing Facilities at Warm Springs

At the turn of the century, the state hospital only served male individuals, in a dormitory type setting. As the demand increased for mental health services, dormitories for both men and women were built and utilized. Many of the dormitories would house upwards of fifty patients per wing, with a large common area and a caged nurses room in the middle. There were no private showers, or bathrooms, and the only thing separating
the rows of beds was a metal nightstand that was bolted to the floor. These large dorm buildings were the standard for care up until about 1950.

The units were huge, and kind of stereotypical psyche ward, very bleak. Most of the buildings were set up so that on one end of the building was a large dorm and there would be forty or fifty men all in beds, just one right after another, no personal privacy no personal space. In the center of the building was the large open day hall and at the other end of the building was a large dorm for the women with the same kind of setup. There were a few buildings that had been built and opened in the late sixties, mid seventies, that had a little more privacy for people that included units that would just have four beds to a room, but still all common shower area, and common bathrooms areas. There was a centralized eating area on campus, and the residents would have to be bussed or escorted to and from their units for meals. Nurses would be responsible for multiple buildings of people per shift, and it could be up to five buildings per one nurse on night shift. (Beausoleil, personal communication, 2005)

Many of the original buildings have been torn down, to make room for newer facilities and administration offices, but there are still a few of the original structures on the campus. Some of these have been renovated to make them usable, others have been shut down and boarded up, unknowingly awaiting there fate. All improvements, new building and demolition is funded by the state through tax payer dollars.

*Mental Health Treatment*

It is a privilege to serve and help individuals in any mental health setting.

“Everybody in this field believes that everybody deserves an opportunity for something
new that may help their symptoms,” (Beausoleil, personal communication, 2005) or give them a chance at a better life.

*The unit system.* Many treatment modalities have been tried throughout the history of Warm Springs. Originally, there was a societal belief that fresh, clean, country air could help cure many mental disabilities, illnesses, and Tuberculosis. The hospital also tried the popular treatments of insulin coma, hydrotherapy, and electroconvulsive shock. With the movement of deinstitutionalization occurring in the mid 1950’s increasing efforts were made to upgrade and modernize the care provided at the institution. With the very successful treatment modality of pharmacotherapy, therapeutic milieu settings and unit systems started to be more common (Warm Springs State Hospital, 1977).

The unit system was implemented in 1967, “whereby patients entering the hospital from three geographical areas were treated throughout their hospital stay by three separate Treatment Teams” (Warm Springs State Hospital Staff, 1977, p. 4). This treatment system contributed to the continuity of care the patient received while at the hospital, and made the transition back into the community easier, by simulating a community setting, much like a therapeutic milieu. The unit system also resulted in A gradual decline of the patient population for they could be served by the community better.

*Milieu therapy.* Milieu therapy coordinates the routines, environments, and actions of the patient while being treated within the Warm Spring’s community. It stimulates the patients by creating a safe area for them to learn and replace maladaptive or deficient attitudes, emotions, and behaviors with appropriate ones. It enables patients
to have interactions with staff and peers and learn how to function and cope with problems, uncomfortable situations, and inappropriate actions. This community enables patients to participate in the planning of their daily routines, and activities. “Through these self-organized and administered milieu groups, patients would begin to develop a sense of citizenship, social responsibility, renewed self-respect, interpersonal skills, and give and take in human relationships” (Warm Springs Hospital Staff, 1977, p. 23).

Deinstitutionalization and Patient’s Rights

Before the civil movement for patient’s rights, it was not unusual for “people to be admitted to the hospital at a very young age and live their entire lifetime there” (Beausoleil, personal communication, 2005). Many times, families would tuck away children, siblings, and even adults that had mental difficulties, or illnesses. It was an acceptable way of treating this population, and was felt to be more humane for the individual and easier on the families than chaining them to walls, or locking them in closets, attics, or haylofts.

In the early seventies, following Senate Bill 377, Warm Springs, Montana State Hospital, followed the trend of the nation and moved people from the institutionalized setting back into communities, and back among society. “We were taking people either by bus or flying them all over the country because of the whole (deinstitutionalization) phenomenon of giving people the right to be served in communities close to their homes and families” (Beausoleil, personal communication, 2005).

The patient population was decreasing due to more services within communities, more effective treatment modalities, more effective pharmacological therapies, and a change in the way society thought about how individual’s care should be provided.
Society felt that it was better to move people back into better living conditions in the communities and start to restructure the institutional environment.

*Mental health commitment and treatment act.* The role of Warm Springs State Hospital changed after the Senate Bill 377, the new Mental Commitment and Treatment Act, passed in 1975. The purpose of the hospital changed from having the responsibility of care and custody of the patients that were committed to the hospital either voluntarily or involuntarily, to requiring the intense and active treatment of the seriously mentally ill of Montana. Prior to this senate bill, the hospital had admitted “everyone whose commitment was voluntarily agreed upon or ordered by the court, regardless of whether or not the individual patient was seriously mentally ill” (Warm Springs State Hospital Staff, 1977, p. 7). The Senate Bill changed the way that the mentally ill and mentally handicapped would be treated, screened and confined in the future at Warm Springs State Hospital.

According to Senate Bill 377, the “seriously mentally ill” person is one who suffers from a mental disorder which has resulted in self-inflicted injury or injury to other, or the imminent threat thereof; or which has deprived the person afflicted of the ability to protect his life or health. (Warm Springs State Hospital Staff, 1977, p. 7)

*Rights of the mentally ill.* When Senate Bill 377 passed, a mandatory reform of the state codes occurred (Title 38-1317, Revised Codes of Montana 1975). These revisions stated the appropriate actions of the mental facility when administering humane treatment that is best suited to the needs of the patient, by respecting the patient’s integrity and dignity while upholding their rights. This was very specific to how a mental
facility could treat a patient, and recognized that patients had rights, and these rights needed to be recognized and upheld.

The new laws that Senate Bill 377 evoked covered the confinement and treatment of persons with mental disorders, but differed from the previous laws in the following ways:

1. the new laws specify that an alleged mentally ill person must be represented by an attorney during the commitment process;
2. the new laws provide for more extensive evaluation of persons alleged to be mentally ill;
3. the new laws broaden the professions which can conduct evaluations of the mentally ill to include Social Workers, Psychologists, Physicians, and Psychiatric Nurses;
4. the new laws emphasize the provision of evaluation and treatment services at the community level rather than at Warm Springs State Hospital;
5. the new laws provide for periodic reviews by the courts of all long-term confinements;
6. the new laws prohibit transfer of patients from one institution to another without a court review;
7. the new laws explicitly guarantee the personal and civil rights of patients confined at Warm Springs State Hospital;
8. the new laws make special provisions for the treatment of minors;
9. the new laws mandate that people who are currently patients of Warm Springs State Hospital receive a review by the court if they are involuntary committed;
10. the new laws spell out in detail the minimum standards for treatment of mental disorders;
11. the new laws have created a Mental Disabilities Board of Visitors to assure that all human treatment rights contained in the commitment laws will be protected. (Warm Springs State Hospital Staff, 1977, p. 8)
With these revisions, and new laws, the patients admitted to a mental facility, hospital, or institution, whether voluntary or involuntary, now had rights. They had the right to treatment, right to refuse treatment, their civil rights, right to least restrictive conditions of treatment, right to a clean and safe environment, and the right to a humane psychological and physical environment.

Requirements of the facility in upholding the rights of the mentally ill. This new “commitment legislation,” put standards for treatment on the facility, and increased the effort of the staff in the care and treatment of the patients. By law, each patient that is committed for a period of more than 72 hours must receive a thorough physical and mental examination, including a review of their current behavioral status within the first 48 hours of the 72 hour stay. Within five days after the patient’s admission the treatment team must develop and implement an individual treatment plan that focuses on the needs of the patient to achieve wellness. This encourages the idea that treatment starts with the admission of the patient to the hospital.

The treatment plan must include the stated problem, and primary needs of the patient. “The law tells us what we have to have on treatment plans, and how often we must review treatment plans,” (Beausoleil, personal communication, 2005) and this makes a mental institution very different from most other hospitals. The treatment plan outlines the least restrictive treatment modality to be able to achieve the purpose of the commitment. The short-term and long-term goals should be stated clearly, but they should also be achievable by both patient and treatment team. Along with the goals, a criteria for reaching and accomplishing each goal should be stated clearly to enable the completion of treatment, and release of the patient. All modalities of treatment, and
efforts by staff should be recorded for team analysis, and future information. Lastly, a
treatment plan must recognize the needs of the patient’s aftercare. The aftercare plan
should be developed simultaneously with the in-patient treatment plan, with constant
review, and revision for the success of the patient (Warm Springs State Hospital Staff,
1977).

*Psychiatric Nursing at Warm Springs, Montana State Hospital*

Quality care in mental health nursing depends on the availability of qualified,
competent staff. The nurse is one member on a treatment team. “There are very few
settings where nurses, on a daily basis, sit down with a psychiatrist and Ph.D.
psychologists and master researchers and LPNs and aides and that whole diverse
treatment team on a daily basis and talk about how best to provide service for an
individual” (Beausoleil, personal communication, 2005). The role of the psychiatric nurse
is complex in the fact that they are expected to provide care for both physical problems as
well as the mental health needs. They need to stay current with disease processes,
assessment skills, and mental health modalities (Carson, 2000). (See Table 2 for the basic
preparation for a psychiatric nurse)
Table 2

BASIC PREPARATION FOR PSYCHIATRIC NURSES.

<table>
<thead>
<tr>
<th>Knowledge</th>
</tr>
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<tbody>
<tr>
<td>- Biological and psychological theories of mental health and mental illness</td>
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<tr>
<td>- Psychotherapeutic modalities</td>
</tr>
<tr>
<td>- Substance abuse and dual diagnosis</td>
</tr>
<tr>
<td>- Care of populations at risk</td>
</tr>
<tr>
<td>- Community as milieu as a therapeutic modality</td>
</tr>
<tr>
<td>- Cultural and spiritual implications of nursing care</td>
</tr>
<tr>
<td>- Family dynamics in mental health and illness</td>
</tr>
<tr>
<td>- Psychopharmacology</td>
</tr>
<tr>
<td>- Legal and ethical dynamics including documentation specific to the care of those with a mental illness (p.1097)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skills</th>
</tr>
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<tbody>
<tr>
<td>- Comprehensive biophysical and spiritual assessment</td>
</tr>
<tr>
<td>- Interdisciplinary collaboration</td>
</tr>
<tr>
<td>- Identification and coordination of relevant resources for patients and families</td>
</tr>
<tr>
<td>- Use of psychiatric diagnosis classification system</td>
</tr>
<tr>
<td>- Therapeutic communication</td>
</tr>
</tbody>
</table>
CHAPTER FIVE

Discussion

For many centuries, health care practitioners and people have held the belief that the practice of psychiatry had little to do with the practice of medicine. Along with these ideals was the division among psychiatrists as to whether mental illness was an “organic” disorder, or primarily related to social influences. The physician’s personal belief regarding physical illness determined the therapeutic modalities used to treat the patient.

The constant battle to overcome the past, and to ensure that government policies “do not limit, or discriminate against the help available for the mentally ill, will continue through the next one hundred years” (Glass & Vergare, 1994, p. 1792). Society needs to continue to strive to recognize mental illness as a disorder that captures people but does not define them. Health care professionals must continue to recognize the role that stigma and suffering have had in the history of the mentally ill and learn and grow from the past.

Diagnosis and treatment of psychiatric disorders have become a science with such publications as the DSM manuals. With literature like this, psychiatric disorders have been defined, and set guidelines have been established to reduce misdiagnosis of patients. Remarkable advances such as the therapeutic milieu setting have taken place and changed treatment. The constant advances in pharmacotherapy have allowed for more effective treatment in the outpatient setting, and have helped to increase services available for mentally ill people (Alford, Coursey, & Safarjan, 1997).

Stigma

“The negative attitude concerning mental illnesses also pervaded the thinking of the public generally, and it is that attitude which has so long stood in the way of better
understanding and acceptance of mental illnesses” (Felix, 1967, p. 83). Stigma, against those that have a mental illness, the people working with the mentally ill, and the mental health system is still very present, and effects millions of people everyday (Corrigan & Lundin, 2001).

Fear and shame about mental illness go back for centuries. It may be one of the oldest prejudices in the United States history, and the idea that an individual or a parent is responsible for the mental illness is slowly starting to fade. Luckily, due to advances in technology, mothers are no longer blamed and ridiculed when their child is diagnosed with schizophrenia. The time of the “schizophrenogenic mother” has passed (Corrigan & Lundin, 2001).

Prejudice and stigma are based on ignorance and myths. The best way to fight stigma is to promote education for nurses, families, patients, and society as a whole. Woolis (1992) suggests that when knowledge, or education are being provided, keep the following in mind: (a) mental illness has a strong biological component, but it affects the thinking process, behaviors, feelings, and judgments of the person suffering, (b) mental illness is not contagious, it cannot be caught like the common cold, (c) mental illnesses are extremely wide spread, and over eight million American suffer from some kind of mental illness, or disorder; this number is continuing to grow and, (d) treatments can reduce symptoms, but many times people are prone to relapse (Woolis, 1992, p. 202).

Social stigma, ironically, does not discriminate. It is not reserved only for the person or family living and suffering with the mental illness. In many cases, it also is extended to the medical/nursing students and residents, psychiatrists, and nurses that have chosen to dedicate their lives to helping those in need. Beausoleil (2005) explained the
reaction that many colleagues, and community members have when they find out she is a nurse at Montana State Hospital, Warm Springs:

If I go back to eastern Montana and somebody says “Where do you work?” and I say, “Montana State Hospital,” they’ll say, “Well, what’s that?” And I’ll go, “Warm Springs.” They reply, “Oh, Warm Springs. Oh.” There’s still all of those kind of comments from people who are well meaning, well educated, and it always kind of startles me because it is still is that kind of level of the mystic, the unknown, the stigma still really is out there.

“Although the stigma of mental illness alone is sufficient to affect treatment and life outcomes, mental illness may not be the only stigmatizing characteristic of individuals seeking or receiving mental health services” (Sanders-Thompson, Noel & Campbell, 2004, p. 530). Discrimination and stigma is well documented for the members of racially diverse populations, and this has been found to increase the social stigmatization when coupled with mental illness. As a society that is formed by the cultural diversity of being the “melting pot,” there are still many underlying racial and ethical problems that need to be addressed. By addressing these, and educating the public on mental health and illness, we may be able to take steps towards a better understanding of how each of us stand as individuals, with unique qualities that should be embraced, not shunned.

“Much concern has been expressed in recent years about the misinformation and lack of information the general population has about mental health and mental illness” (Wahl & Kaye, 1992, p. 21). The American Psychiatric Association, along with the National alliance for the Mentally Ill, have established Mental Illness Awareness Week
(Fink, 1987) while other organizations such as the American Mental Health Foundation and the National Mental Health Association have also made concerted efforts to communicate information to the larger community. One element of the strategies of these organizations has been to “encourage publication of mental health information outside of professional journals or specifically mental health or advocacy publications” (Wahl & Kaye, 1992, p. 22).

“In fact, most people still do not understand mental illnesses. As a result, many are afraid of those with a mental illness or think such people are weird; in either case, they want nothing to do with them” (Woolis, 1992, p. 15). These beliefs leave people that have mental illnesses not only disabled by their symptoms, but isolated and rejected by others. “They may therefore feel alienated, empty, lonely, rejected, and depressed. As a result of this, they often withdraw from people and activities, lose interest in the world, and become mistrustful” (Woolis, 1992, p. 15) It is the responsibility of society to search for knowledge that will empower the patient, the person, and the social culture as a whole.

*Therapeutic Community*

The therapeutic community was a revolutionary movement that stemmed from the Mental Health act of 1959, the advances in pharmacotherapy, and deinstitutionalization. The milieu setting supported the idea of having smaller cottage settings for community care, and was essential in the understanding of the person. Many nurses supported this movement for they saw it as “a revolt against a dehumanizing process” (Campbell, 1979, p. 1986) which many felt was the repercussion of organically-minded psychiatrists, institutions, and experimental therapies.
The therapeutic community also encouraged moving away from the “locked ward” or “closed ward” setting to a more open ward policy, where the patient had their personal rights upheld, and could leave (Crowhurst & Bowers, 2002). This was a progressive movement, but proved to be of real benefit in the treatment of a large percentage of the individuals.

*Psychiatric Nursing*

The role of the nurse has changed rapidly in the mental health setting. When the National Mental Health Act of 1946 was enacted, the role of all professional mental health care providers started to change. One of the purposes of this act was to increase the supply of mental health professionals. Nurses were allowed to work within two psychiatric settings: the psychiatric/mental health registered nurse or the psychiatric/mental health advanced practice nurse. The idea was to make mental health a specialty field, where the patient could get more comprehensive care (Townsend, 2006).

Historical changes and policy shifts have resulted in primary care providers playing an increasing role in the care of mental health problems. Such problems are common within community settings and a major cause of suffering and disability. Nurses in particular are likely to encounter a high level of psychological co-morbidity in their patients. (Haddad, Plummer, Taverner, Gray, Lee, Payne & Knight, 2005, p. 976)

With complex changes occurring within the services linked to the reforms of the health service, mental illness and the treatment of individuals with mental illness is ever changing (Coleman & Jenkins, 1998). The care and well being of the patient is an ethical commitment and responsibility that each psychiatric nurse has. It is also the responsibility
of the nurse to be the advocate for persons suffering from a mental illness or mental disorder. We need to work towards fighting prejudice and stigma and improving the conditions for people with mental illness. Woolis, (1992) suggests the following:

(a) continue to educate yourself and other by participating in national, state, and local chapters of NAMI, (b) actively respond to prejudiced or incorrect information in the media or among friends and relatives, and (c) offer support to families struggling with having a loved ones’ diagnosis, and volunteer with agencies serving people who have mental illnesses or with support groups for families and friends. (Woolis, 1992, p. 203).

The opportunity for the psychiatric nurse to be both advocate and educator is unique. Due to job diversity in nursing, all nurses will, at some point in their careers, have the opportunity to care for a person with a mental illness. Due to this, and having the opportunity to specialize, the nursing profession is in a position to promote the education and positive treatment towards mental health. It is important for nurses to recognize this opportunity and help to educate society towards continuing the slow change in regards to stigma, language and treatment of mental illness.

The Future

The history of the human race is filled with examples of new discoveries and knowledge fighting for acceptance against pre-existing beliefs, and natural laws. The fight for better understanding and acceptance within mental-health is no different. It's important to be able to talk and educate the public, in trying to get a different message out about how mental illness is not a death sentence. Nurses need to help society understand, that we serve people who are underserved and who cannot advocate for themselves, or at
least typically have a lot of difficulty advocating for themselves. As a profession, nurses need to do a better job, at promoting knowledge. As a society, we need to spend more money; in a country that is as wealthy as our country, we could do so much more the for patient, and the family. “We need to do better for the patient and the family” (Beausoleil, personal communication, 2005).

To promote the human and civil rights of people in and out of psychiatric treatment situations, with special attention to their absolute right to freedom of choice. To work toward the end of involuntary psychiatric interventions, including civil commitment and forced drugging, restraint and seclusion, holding that such intervention against one’s will is not a form of treatment, but a violation and of the right to control one’s own body and mind. (Bassman, 1997, p. 167)

Personal choice is fundamental to the growth and recovery of patients, families, care givers and the social structure. Freedom of choice that is fueled by knowledge and educated decisions are choices that promote health, wellness and well-being.

In conclusion, here have been great strides in the advancement of treatment modalities, technology, pharmacology, and care of individuals who are mentally ill. There is still much room for improvement for we have not completely learned from the mistakes of the past. The treatment of the mentally ill goes beyond the chemical imbalances, and somatic treatments; it is the interaction, compassion, and understanding that each individual deserves, but few are shown. Nurses must strive to avoid labeling the client by the disease, or disorder. Client’s who have mental illness must be seen as unique and special individuals that suffer from the illness, but are not defined by it.
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