IMPLICATIONS OF DEVELOPMENTS IN PSYCHIATRIC TREATMENT FOR REHABILITATION

C. H. Patterson

Part 1: Developments in Psychiatry

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The purpose of this paper is threefold: (1) to summarize recent developments in the treatment of the emotionally disturbed, (2) to delineate the current situation and the problems that are posed in psychiatric rehabilitation, and (3) to consider the implications for what are termed aftercare programs, including the halfway house.

Advances in Treatment

The professional and the lay literature is replete with statistics on the increasing rate of discharge of patients from mental institutions. From 70 to 80 per cent of patients admitted to our best mental hospitals are discharged within a year after admission. In spite of population increases, the total population of our mental hospitals has been declining for several years. In his message to Congress, President Kennedy (23) declared that with a broad new mental health program, the number of patients in mental hospitals can be reduced by one-half within a decade or two. The mood is one of optimism regarding the cure or alleviation of emotional disturbances. President Kennedy (23), referring to developments in psychiatric treatment, stated:

> ". . . these breakthroughs have rendered obsolete the traditional methods of treatment which imposed upon the mentally ill a social quarantine, a prolonged or permanent confinement in huge, unhappy mental hospitals where they were out of sight and forgotten. . . . I am convinced that, if we apply our medical knowledge and social insights fully, all but a small portion of the mentally ill can eventually achieve a wholesome and constructive social adjustment. "

This optimism has developed with the increasing use of the tranquilizing drugs in the past 10 years. These drugs have been credited with much of the success in keeping the mental hospital population down. The effectiveness of drugs in altering behavior in psychiatric conditions is not to be denied. They have contributed to a revolutionizing of psychiatric care. To a great extent they have replaced sedation, restraint, seclusion, shock treatments, and brain surgery. But they are not the panacea that some of the public believe they are. Medical and psychiatric opinion, as well as psychological and sociological opinion, is in essential agreement that "drugs do not, and will not, restore patients to mental health. The effect of drugs seems so far to have been an indirect effect" (17).

There are those, however, who are convinced that all psychiatric conditions are organic in etiology, and see the hope for cure in the area of drugs. They cling to the paretic psychosis as a model, and the search continues for an organic etiology that can be treated and/or prevented. There are, of course, organic psychoses, including alcoholic and other toxic psychiatric conditions. And there are, also, constitutional and hereditary factors or elements in other psychiatric conditions, as there are in all behavior. There are neurological or physiological concomitants in the so-called functional disorders. These, however, may be the result of the condition rather than having a causal relationship. Looking at the situation from another standpoint, we must recognize that, although there are neurological and physiological elements in all behavior, behavior is also influenced by psychological and social factors. It is only reasonable to expect that disturbances in the social-psychological environment will result in disturbances of thinking, emotions, and behavior. These disturbances may reach psychotic proportions. Thus, without denying the existence of organic psychiatric disorders, we must also recognize that there are disorders that are social-psychological in origin. In his presidential address to the American Psychiatric Association, C. H. Hardin Branch (6) disposes of the organic point of view as follows:

"In some areas there appears to be a philosophy of waiting until the final definitive answers to mental, as well as physical, illnesses are found at the molecular level. However, as long as there are human personalities which are forced to establish relationships with their environments, it is unlikely that intervention at this level will actually eliminate the incapacitated person."

So there are two kinds of so-called mental illness, the organically determined and the social-psychologically determined. The nature of these conditions, while apparently similar in some behavioral manifestations, is entirely different and they require different methods of treatment. There are those, e. g., Szasz (34), who feel that the two conditions are so different that they ought not be considered together, and that the analogy between mental illness and physical illness is only an analogy, and a poor and dangerous one.

This topic has been considered because it has an important bearing upon the nature and future of psychiatric rehabilitation. If emotional disturbances were organic in etiology, then rehabilitation would follow the pattern of rehabilitation in the physical disabilities. Rehabilitation would not be centered in the social-psychological area, as it now is. It would of course be necessary to consider social implications in the same way as we now do in the case of the physically disabled. As Williams (36) points out, regardless of the etiology there are social-psychological symptoms present. In the case of partial "cures," where residual symptoms remain, we would still need to be concerned with social-psychological rehabilitation, also.

The social-psychological aspects are in many cases more than mere symptoms. They are the core, the essence, the inherent nature of the condition. Whether we view the disturbance as breakdown in communication, isolation from the community, disturbance in personal-social interaction, or as a moral problem (cf. Mowrer, 26), it is social-psychological in nature. Evidence that much of psychiatric disorder is of this nature is found in the efficacy of treatment which is directly related to social-psychological factors. The increasing rate of discharge in our mental hospitals not only coincided with the introduction and increasing use of drugs, but also with the development of a more humanistic approach and atmosphere. The shift is well characterized by

the title of one of the books describing this social-psychological revolution in the environment of the mental hospital: *From Custodial to Therapeutic Care in Mental Hospitals* (16; see also 3, 8, 13, 14, 15, 33). This movement is not a new approach to emotional disturbance, however. It was essentially the approach used, under the designation of "moral treatment" over a century ago in American mental hospitals (4, 7, 16). Discharge rates in our mental hospitals then were as high as the highest reported today.

The essence of this approach is basically simple. It consists of treating the patient as a human being, as a person, with respect for his personality, individuality and humanness, with interest and attention to his social-psychological needs, his feelings and concerns. The terms social psychiatry, therapeutic community, and therapeutic milieu have been used to refer to the concern with the total social environment of patients. Results with the use of this approach alone, without drugs, appear to be as spectacular, in terms of changes in behavior, as are those obtained by the use of drugs. The so-called placebo effect is of interest here. There is some evidence in controlled studies that patients treated by a placebo respond as well as do those given other specific treatments, such as an active drug. This so-called placebo effect has been recognized as the result of psychological factors--interest, concern, and attention, as well as prestige, authority, or suggestion. The point might be made that the placebo effect is not something to be eliminated in the treatment of the emotionally disturbed, but that it is a real and a pertinent method of treatment. That is, the factors leading to the so-called placebo effect are not extraneous, but constitute the specific remedy for emotional disturbance. They are the common and effective elements in psychotherapy; they are the effective aspects of social psychiatry and the therapeutic milieu.

There has thus been developing a new approach to psychiatric disorders. This approach reflects the recognition of social-psychological factors. It consists of a move from the "total institution" concept (12), where the patient is removed from the community and isolated in a setting that provides for his needs for subsistence, toward the community health center concept. In this approach the attempt is made to keep the patient in his home community for immediate, active treatment, designed to eliminate the need for commitment to a mental hospital with its attendant negative aspects. It is more than outpatient mental hygiene clinic treatment, however, and may include residential treatment in a hospital setting. It may consist of a psychiatric unit as part of a general hospital, or may consist of a special center. The Butler Health Center in Providence (19) is a day program of this type, which provides individual and group psychotherapy, medication, occupational and related activities, and ward or room care for those who cannot participate in any activity. Only after failure of treatment in the community health center is the patient hospitalized in a mental institution. President Kennedy (23), in his proposed program for mental health, provided for support for comprehensive community mental health centers. He indicated this would include diagnostic and evaluation services, emergency psychiatric units, outpatient services, inpatient services, day and night care, foster home care, rehabilitation, consultative services, and mental health information and education. This program is based upon the recommendation of the Joint Commission on Mental Illness and Health (21, p. xiii) that "immediate professional attention should be provided in the community for persons at the onset of acutely disturbed, socially disruptive, and sometimes personally catastrophic behavior" through community-based clinics or hospitals.

In addition to modifying their treatment methods, mental hospitals are extending their services in new approaches to the needs of patients. Day hospitals and night hospitals are being provided, so that patients may live out of the hospital during the day or during the night, depending on their needs. Employment in the hospital is being developed and used as part of the rehabilitation process (cf. the Member-Employee program of the Veterans Administration [30]). In some instances the entire hospital is being reorganized as a therapeutic community (22). Foster home placements are being increasingly used by some hospitals.

The point is that the treatment of emotional disturbances has become social-psychological in orientation, as the basic social-psychological nature of the disorder has been recognized and more generally accepted. Emotional disturbance, viewed as alienation from the community, leads to recognition of the importance of attempts to reinstate, restore or reintegrate the individual in the community. Treatment has thus expanded from individual psychotherapy and physical or physiological measures, including drugs, to group therapy and various other socially oriented therapies both within and outside the hospital. The term social psychiatry is being increasingly used to refer to this new concept of treatment. Recognizing that hospitalization outside the community has disadvantages, efforts are being made to treat newly developing cases of emotional disturbances in the patient's community in order to avoid possible further alienation from society.

Greenblatt (in 24, p. vi) expresses the goals of this approach to treatment in the form of some questions: "Can day care wholly or partially replace full-time hospitalization? Does the concept of hospitalization and the corollary use of beds encourage regressive dependencies, and do these regressive-dependent trends foster chronic disease, custodialism and other undesirable consequences? Does the existence of the full-time, long-term mental hospital also encourage communities, states, and nations to abdicate responsibility for the treatment and rehabilitation of the mentally ill?"

Do We Need Aftercare Programs?

If the application of these new approaches and methods can lead to discharge rates from our hospitals of 70, 80, or 90 per cent, is there then any need to be concerned about aftercare services in the future? With short-term hospitalization reducing or even eliminating institutionalization, will halfway houses and similar programs be needed?

The answer to this question is that even if so-called specific treatment programs are as successful as it appears they are, services that are now included under the term aftercare services will still be necessary and important, even more important than is now recognized. First, such services will be important in reducing the readmission rates for discharged patients from the 30 to 50 per cent that now exists. Second, and more important, what are now called aftercare services will be recognized as part of the treatment services, and will be used as such and not limited to aftercare programs. The nature and organization of these services may be changed; it is our purpose to consider these possible changes in the next section of this paper.

It should be apparent that it is necessary that aftercare programs be related to the nature of hospital and other treatment of emotional disturbance. The problems to be faced by such

programs will be related to the nature of the prior experience and treatment of the emotionally disturbed individual. If emotional disturbance is an organic condition, to be treated and cured by drugs, then the problem will be of one kind. But if, as appears to be the case, emotional disturbance is essentially an alienation from the community, then the nature of aftercare services will be of a different kind.

A look at the existing aftercare services suggests that they have developed without much relation to psychiatric treatment programs or facilities. Or perhaps it is the case that, where treatment services and facilities have been undergoing so much change, there has been no firm basis upon which aftercare programs could be built. What has happened is that different programs have developed to meet the varying needs of ex-mental hospital patients. These include psychiatric aftercare clinics (25) or the usual mental hygiene clinics or mental health centers. There has been considerable interest in sheltered workshops for the discharged patient (28, Chapter 14). Foster home placements have been utilized more frequently. Social clubs have been developed by patients, themselves, or fostered by professionals. And so-called halfway houses, residential and non-residential, and offering varying kinds of services, have developed. There appears to be no pattern or organization of services among all these programs.

The Joint Commission on Mental Illness and Health (21, pp. 270-271) makes the following recommendation regarding aftercare, intermediate care, and rehabilitation services:

> "The objective of modern treatment of persons with mental illness is to enable the patient to maintain himself in the community in a normal manner. To do so it is necessary (1) to save the patient from the debilitating effects of institutionalization as much as possible, (2) if the patient requires hospitalization, to return him to home and community life as soon as possible, and (3) thereafter to maintain him in the community as long as possible. Therefore, aftercare and rehabilitation are essential parts of all service to mental patients, and the various methods of achieving rehabilitation should be integrated in all forms of services, among them: day hospitals, night hospitals, after-care clinics, public health nursing services, foster family care, convalescent nursing homes, rehabilitation centers, work services, and ex-patient groups."

The Commission points out that "aftercare services for the mentally ill are in a primitive stage of development almost everywhere, in social service, public welfare, and vocational rehabilitation agencies as well as in mental hospitals and psychiatric clinics. Where they do exist, services and agencies caring for the former patient tend to split off from mental patient services as a whole, and, further, to approach the patient's problems piecemeal" (pp. 271-272).

The Commission was concerned with treatment, however, rather than aftercare services, and it does not go into this area further than to recognize its importance and to encourage various kinds of efforts. There is no attempt to delineate the kinds of services needed and their relation to the developments in treatment programs. It is the purpose of the next part of this paper to suggest the nature and organization of aftercare services and rehabilitation that would appear to follow from the developments in psychiatric treatment that have been summarized above.

Part II: Some Implications for Psychiatric Rehabilitation

These developments in the treatment of the emotionally disturbed should have some implications for the nature and organization of the aftercare and rehabilitation services that these clients need. Let us consider some of these implications.

1. *The assumption that much emotional disturbance is a problem in living, or in interpersonal relationships, means that we cannot expect miraculous cures to be discovered--no simple, quick panaceas*. We cannot therefore postpone developing adequate programs of aftercare services in the hope that some complete cure will be forthcoming which can be applied in a hospital and which will leave patients with no residuals and thus no need for resocializing or rehabilitation. We now know the nature of the essential requirements of both cure and prevention. They rest in the basic principles of good human relationships. Certainly we can expect the development of more effective means of applying these, both in everyday life for prevention and in therapy for cure. But it is unreasonable to expect that, where there is a long history of inadequate social relationships, we will be able to change the situation easily or quickly, either by drugs or psychotherapy or by any other means. We must be ready to expend time and effort in the resocialization of those who have had long periods of estrangement from society.

2. The recognition of the social-psychological nature of much emotional disturbance provides the rationale and direction for the kinds of services needed. If the patient has become separated from the community by his disturbance, then he needs to be restored to the community. Drugs and other methods of treatment help to make the patient more acceptable to others, or to make him more acceptant of others so that relationships can be reestablished. But more than this is necessary for many if not most patients, particularly for those who have been away from the community for a long period of time. They need assistance in the transition back to normal, everyday society; they need bridges by which they can make connections as a beginning for resuming social or communal living. Group or individual psychotherapy is a beginning in the establishing of relations with others. The core of the required services is social-psychological in nature. The emphasis in many aftercare programs upon socialization, developed on an experiential or empirical basis, is supported by the developing concept of the nature of emotional disturbance.

The increasing discharge rate from mental hospitals means an increasing problem for aftercare services. For these ex-patients, especially those whose discharge is facilitated by the use of drugs, are not "cured" in the sense that they have been reintegrated into society. They are merely free from some, but not all, of the symptoms that developed with their estrangement from society. They are therefore only ready for the crucial step of re-entering society. Discharge from the hospital is only evidence that they are considered ready for this step.

It may be true that those who have had brief, intensive treatment in a community-based center, or short-term hospitalization, need little or no assistance in returning to society. But at present, and for a long time to come, these will constitute only a part of the potential clientele of aftercare services. Many, if not most, of those needing services have had long periods of hospitalization. Although treatment in mental hospitals is changing, this change has not occurred in all hospitals,

and many patients now being discharged have had long periods of hospitalization in custodial institutions (32). They have adjusted only too well to institutionalization, to life outside society. They have become dependent on others for routines and decisions of everyday living. Thus, as Williams (36, p. 1) notes:

"Much of the disability seen in the mentally ill is not necessarily inherent to the disease process.... Social crippling is often a by-product of the social experiences and deprivations to which the mentally ill are commonly subjected .... Perhaps the most important source of disability is that almost total immobilization of function imposed by the mental hospital as it is often operated today."

We see the paradox that a disturbance that is characterized by loss or failure of communication with society has been treated by further isolating the patient from society. No wonder our mental hospitals have filled up with terminal cases. Many patients have recovered from their basic disturbance but have been made incapable of returning to society. Some, perhaps, could return if given the opportunity to re-establish contact. There is a story that when the Germans overran France during the war they opened a mental hospital and let the patients out. The patients were never discovered, apparently being absorbed into society with no problems.

Thus while the newer approaches to treatment, particularly early community-centered treatment and drugs, may reduce the dependency that many discharged patients now exhibit, there are still many patients now in our hospitals who will need aftercare services. There will continue to be long-term patients who will need services both because it will be a long time before early community treatment is generally available, and because there will always be those needing long-term care who will, despite the best treatment in the hospital, require some help in the transition from the hospital to the community.

3. *With the developments in treatment methods and procedures, including early treatment in the patient's community, it appears that it would be desirable to reappraise the various aftercare services existing to determine if they are adequate*. This would include an evaluation of whether all necessary or desirable services are available, and whether they are provided in the most effective way for those who need them. The relationship of the individual to society involves many aspects, which may be grouped or classified in different ways. Williams (36, p. 2) suggests four major types of social interaction: family life, working life, the life in clubs and voluntary associations, and the life of recreation. It would appear that existing services are directed to meeting needs in all of these areas. Foster homes and residential houses, together with social work services, provide help in the family area. Social clubs and halfway houses provide assistance in the area of voluntary associations and recreation. Vocational counseling, training and placement services, and sheltered workshops provide assistance in the area of work. The question is, are these services organized and provided in the most efficient and appropriate manner to meet the needs of clients? As was indicated above, these various services have developed piecemeal and independently. It is time that consideration be given to determining if there might not be a better way of providing these services.

A possibility is the application of the comprehensive rehabilitation concept which has led to the development of rehabilitation centers for the physically disabled. The organization of services to

the emotionally disturbed could lead to the development of comprehensive psychiatric rehabilitation centers. The Vocational Rehabilitation Administration (VRA), in its suggestions for the development of rehabilitation services for the emotionally disturbed (35, p. 15), proposes a similar approach:

Halfway houses with expanded and coordinated services should be established. This kind of house would add to the usual residential facilities a systematically planned and unified program of vocational training, psychiatric consultation, casework service, and therapeutic group activities, in a community setting.

This would approach in nature a psychiatric rehabilitation center, providing a continuity of services for those at various stages of recovery or resocialization.

4. *The development of community treatment centers for early treatment of emotional disturbances has implications for the terminology we have been using.* Many of these services may be appropriate for those who are being treated in these centers as well as for ex-patients. That is, services that have been provided for those discharged from mental hospitals may be useful for others who have not been patients in a mental hospital. Thus the term "aftercare" is not appropriate. Similarly, "halfway house" is hardly applicable to facilities that deal with individuals who have not been hospitalized.

Some Questions and Problems

One of the greatest handicaps of the emotionally disturbed and ex-mental hospital patients is the stigma attached to them. Terms such as "mental illness," "mental patient," "mental hospital," "psychiatrically disabled," etc., label them in a way that stigmatizes them and affects their acceptance by the community. There is thus a problem of terminology, particularly in the case of those who have been hospitalized (31, 1963). I have used the term "emotional disturbance" to refer to these people (28), a term that seems to be increasingly adopted. Perhaps we should not talk of psychiatric rehabilitation centers, or even mental health centers, but of *social* rehabilitation centers or simply social centers. Even "aftercare services" may stigmatize and, as has been pointed out, these services are not necessarily limited to ex-patients

Because of the stigma attached to any special services, regardless of labels, that identify a person as an ex-patient or emotionally disturbed, consideration must be given to the detrimental aspects accompanying identification of an individual with such special services. These services thus have costs, or disadvantages, as well as benefits, as Olshansky (27) points out. They must be weighed in determining whether a particular individual should be provided special help, or be allowed or encouraged to re-enter society with no special help.

Another question related to the current approach to the treatment of the emotionally disturbed concerns the nature of some of the methods which are not therapy? In the area of physical medicine, rehabilitation services are distinguished from treatment. The former are services that are not specific or definitive in terms of the disability, and are rendered after the acute phase of the condition has passed. It is sometimes difficult to separate the two, however. In the case of the emotionally disturbed the distinction becomes more blurred, and more difficult, if not

impossible, to make. If emotional disturbance is not an illness in the usual medical sense of the word, but a disturbance or disorder in interpersonal relations resulting in problems of living (Szasz, 34), or a disturbance of communication with an alienation from society, then any method that deals with this area such as resocialization through social group work, social clubs, recreation, etc., (in fact any activity involving interpersonal activities or interaction), is specific to the disturbance and is treatment rather than rehabilitation. Psychotherapy, both group and individual, and drug therapy are thus not the only (specific) therapies for emotional disturbance.

While it is thus becoming apparent that it is not possible to separate so-called therapy or treatment from rehabilitation or aftercare services present programs for the emotionally disturbed usually attempt to preserve this artificial dichotomy. Federal support programs break the services into these two areas. However, it appears that the Vocational Rehabilitation Administration can provide support for study and research in aftercare or rehabilitation services that also include treatment services (36). VRA nevertheless continues to divide services into treatment and rehabilitation. On the other hand, the Community Mental Health Centers Act of 1963 includes the term "rehabilitation" in its definition of community mental health center. It appears that there is a need to reappraise the situation with regard to the possibility that the attempt to distinguish between these services interferes with the continuity of services which the individual needs.

The providing of various services, including what is now called treatment and rehabilitation, in a single setting such as a community mental health center, as suggested above, may not be the only or best way of working with the emotionally disturbed. Research centers, it appears, will usually be connected with hospitals, which may have some disadvantages. It is probably desirable to experiment with a variety of mental health centers in terms of character, location, staffing, sponsorship, affiliation and methods of operation. Not all community health centers should be hospital based. Hobbs (18), referring to mental health centers in his testimony to Congress as a representative of the American Psychological Association, stated: ". . . if they are limited in conception to repetitious appendages of hospitals, albeit general hospitals now and in the heart of the city, they will surely be a tremendous disappointment and a latter-day barrier to experiment and innovation."

An alternative to the centralization of services would be to accept the present proliferation of partial services, but to attempt to mobilize these for individual clients, according to their needs. This would require a single reviewing team for all clients, and thus a single clearinghouse for all applicants for services. While this approach would appear to have the advantages of allowing for the independence of agencies and for the freedom of voluntary agencies to provide the services in which they are interested, as well as for the separation of some services from a hospital or medical setting, there are also disadvantages. These disadvantages include the overlapping of some services and lack of others, and the problem of integrating these services in the best interest of the individual client. The centralization of services can allow for contributions and participation by voluntary agencies, and does not require that all services be provided in a central physical location.

Another problem is the apparent dilemma posed by the fact that our goals for the client include independence, responsibility, and maturity in interpersonal relations, but since he is not able to function in this way we must be protective, assume certain responsibilities for him, and provide a

special (therapeutic) kind of interpersonal relationship. We must recognize this problem, and so organize and provide services that we do not increase or prolong dependence. Each client must be given all the responsibilities he can assume or feels he can assume, all the independence of which he is capable, and no more protection than he needs. The aim should be to challenge without threatening. Too often we do not recognize the capacity of the client to take responsibility or to be independent. On the other hand, we must try to avoid requiring too much, although failure may not be as traumatic or as damaging as we sometimes fear. The goal should be the gradual development of independence and responsibility for the self until the client is ready for society without the need for special facilities or groups.

It becomes difficult not only to determine who needs and can benefit from various services, but also when, and how, to terminate services to individual clients. Should each client be allowed to determine for himself when to terminate or should he be "discharged," eased out, or referred elsewhere? Perhaps a combination of methods is best. Certain services may be eliminated by the nature of the client's progress; e. g., when he takes a job, or goes to a sheltered workshop, he can no longer attend daytime functions, but may need to maintain participation in evening and weekend activities.

A related problem concerns the nature and extent of socialization that is expected of clients. There are many clients who do not want or need extensive social activities. For them the cultural stereotype of the outgoing, socially aggressive extrovert is not a possible nor a desirable goal. We must be careful not to impose our own concepts of socialization on all client.

Finally, the question of the nature and extent of working with the family must be considered. The family is the primary social group in our society. Its importance for success in adjusting outside the hospital and in rehabilitation has been amply demonstrated (Freeman & Simmons, 11). There is thus a strong tradition and emphasis in working with families and relatives, usually through the social worker. There are, of course, those clients who have no close relatives or families, and for them one of the functions of aftercare service is to provide a substitute through foster home placement or residential houses. There are other cases in which the family does not want the former patient back, particularly if there has been a long period of hospitalization. Then there are situations in which the family environment is not a favorable one for the client, and it appears to be desirable to provide a substitute.

But emphasis on the family may be overdone. Even where an apparently adequate family environment is available, there is a question as to how far an agency should go in working or attempting to work with the family. One question involves the imposition of unwanted services. There is some danger that we are tending, in some areas, to interfere with individual desires or to invade individual privacy in our efforts to help people. Perhaps we should be more concerned about imposing unwanted services on the family. In addition, as Jacobs (20) pointed out, our clients are adults, and we should not only respect their rights and desires concerning involvement with their families, but we should also recognize that they may wish, and be able, to work out their family relationships themselves.

Of course services can be offered to families, at the request of clients or with their knowledge and consent. There is certainly a place for various kinds of relationships with and working with

family members. This may be the usual social service activity with the family, in which family members are seen in the home or in the agency for casework services. But it may go beyond this, and there are instances where families are becoming involved in activities with the client. There are also developments in group counseling or therapy with family members--parents, husbands or wives-and with single families as a whole (1, 2, 9, 10).

Summary

Recent developments in the treatment of emotional disturbances emphasize the social-psychological nature of the condition. Treatment focuses upon the preservation or restoration of interpersonal and community relationships, with efforts being directed toward providing early treatment in the patient's own community.

These developments have implications for the nature and organization of so-called aftercare services. These services have grown up in a piecemeal fashion, with little planning or organization. It is suggested that these services be developed and organized around the concept of the broad restoration of the individual patient or client to society. The possibility of comprehensive psychiatric rehabilitation centers is presented. However, because of the stigma attached to the terminology in this area, avoidance of such terms as psychiatric, mental illness, mental disorder or disease, or ex-mental patient is suggested.

The social restoration of the individual is a long process beginning with admission to the hospital for those who require hospitalization. There is no sharp break in the needs of the individual at discharge from the hospital. The social rehabilitation center thus is a continuation of services that are provided in the hospital, with some additions to assist in the transition of the individual to full social standing. These services consist of various therapies, including drug therapy and the various psychotherapies, vocational counseling, recreational and social activities, etc. Individual clients may need only one, or various combinations, of these services, which are thus provided on an individual basis. In addition to these centralized services, it is possible that additional services may best be provided outside a center. These include sheltered workshop services, vocational education and training, social clubs and rooming houses or residences for those individuals without adequate family resources (29).

"The long-time interest in practical techniques for social restoration of mental patients has only recently begun to have an effect" (17). It appears that now is the time to consider how various services can be provided and organized for most effective use by those who need them. The halfway house, with its major concern with resocialization, has been conceived as one service or a step in the transition from the hospital to the community. It is suggested that, since resocialization is the central problem in the treatment and rehabilitation of the emotionally disturbed individual, the halfway house or its central concept become the core around which all services to the emotionally disturbed person, whether he has been hospitalized or not, be organized. The resulting organization, whether called a community mental health center, a psychiatric rehabilitation center, or a social center, is essentially a social restoration center for emotionally disturbed people, that is, people with social and psychological problems of living.

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