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INDICATIONS FOR LONG-TERM PSYCHODYNAMICALLY ORIENTED HOSPITALIZATION

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EDITOR'S NOTE

Once a frequent practice in psychiatry, hospitalization in a long-term psychodynamically oriented setting has become increasingly uncommon as the cost of medical care has risen, managed care has become widespread, drug treatment and short-term hospitalization have become routine, and social mores and expectations of therapy have changed. In this lesson, the author points out that there is still a place for hospitals which provide this kind of care. Moreover, the concept of long-term hospitalization does not necessarily imply long-term hospital confinement; most such programs extend into the community with half-way houses, rehabilitation programs, and outside living arrangements as part of the overall treatment plan.

When should therapists consider this alternative? The usual reason to recommend long-term hospitalization is because the current plan for treatment has failed, the resources in the community are no longer adequate, and the patient, family, and therapist have become exhausted in their efforts to get results. It's not an easy choice. The treating psychiatrist may find it difficult to accept his or her "failure." As he approaches such a recommendation, he would often do well to seek consultation with an appropriate colleague. The patient and family should be actively involved in the choice, visiting the hospital much as youngsters and their families visit colleges they are thinking of attending.

The long-term treatment center can offer very special advantages over acute care facilities. This is easily seen in the treatment of patients such as those with borderline disorders, with whom the long-term interaction with the staff assumes unique therapeutic dimensions, and in the treatment of schizophrenic patients where integration of various modalities from psychopharmacologic intervention to psychosocial rehabilitation is so critical to success.

"I wanted to shout no, but I could not find my voice. It was a moment of helplessness. . . and of decision, like so many of those Hillary and I had tried to make during the past months. . . The decision to hospitalize Rickie was that kind of choice, as if, unable to think of alternatives, we happened to agree." F. Flach, *Rickie*, p. 7.

Introduction

The decision to refer someone for long-term psychodynamically oriented hospital treatment depends on three clusters: the patient and family, the therapist and colleagues, and the community and its existing programs. When any one of those reaches a critical level of exhaustion or is threatened by unpredictable danger, long-term treatment is indicated. How can the referring therapist guide the family to the appropriate institutions, which are themselves changing at the escalating pace described in Alvin Toffler's *Future Shock?*[1]

Patients enter such programs having endured what are often frenetic efforts to reverse their illnesses. Current approaches initially emphasize defining physiological imbalances within the central nervous system. When those efforts fail, both patients and professionals experience defeat. Without clear explanations and crisply defined approaches, sometimes they turn to psychodynamic programs for insight and strength.

Knowing One's Home Territory

Before sending the patient away any distance, the therapist must first consider nearby resources that may allow the patient and doctor to continue their work with local institutional support. Both the psychiatrist and that program might profit immeasurably from such mutual enhancement. If unmanageable difficulties persist, the therapist could confidently proceed to long-term hospitalization as the logical next step. The family will accept it more readily, recognizing that the clinician has assiduously attempted to avert this step.

Knowing What's Out There

Next, **consider visiting some long-term hospitals. Such visits provide a sense of our profession's evolution that reading the literature and attending meetings cannot supply.** Such visits have a great tradition: a century ago, tourists such as Mark Twain and Charles Dickens[2] routinely visited a country's institutions along with its natural landmarks and grand museums. They visited schools, prisons, mental hospitals, and orphanages, talking with staff and residents and seeking the widest possible range of encounters. Now we are more timorous, isolated, and limited in our travel objectives, even though we travel many more miles.

A trip to a professional meeting should ideally include a day to tour that city's mental health facilities, **both state and private hospitals and rehabilitation programs. Program committees for national meetings should routinely facilitate such tours as part of their objective of continuing medical education.** We should appreciate the diversity of ingenuity amid the rapid evolution in health care delivery.

Knowing a particular institution early in one's career, it can be fascinating to return years or decades later. For example, Dr. Morris Schwartz, co-author of *The Mental Hospital*,[3] spent two years at Chestnut Lodge conducting a sociologic study of one ward: three decades later, he returned for a visit. "Nothing at all looked familiar. He felt that if a series of photographs of the current Main IV had been mixed in among pictures of places where he had never been, he would have been unable to identify them as the place where he had once had such intense experiences...[He said] that the place he encountered in 1985 was more like a college dormitory than like the Chestnut Lodge he remembered." Now in 1990, that former Victorian hotel no longer houses patients: they now live in spacious new, homey buildings. **To see a place once is not to have seen it forever.**

Research on Outcome

Today, outcome studies of psychodynamic residential programs become outdated before reaching publication. Programs change rapidly, accommodating outside pressures and clinical advances. **The literature on long-term hospitalization is in disarray. "Long-term" may refer to a scant 24 days[4,5] or a few months,[6]** intervals insufficient for the open-ended evolution of personal development. Likewise, there is a lack of consistent variables in the studies that compare short- and long-term treatment[7] **whose statistical models are fraught with difficulties.**[8] Additionally, most of these "studies...generally excluded the most disturbed patients, e.g., acutely suicidal patients," and those leaving against medical advice.[9]

Some writers stand as advocates[10-13] and others as deriders[14,15] of institutions offering a long-term approach. Although some studies have substantiated the efficacy of such programs[16-21], others challenge their impact.[9] After a thorough review of studies on predicting the length of a hospital stay, Caton and Gralnick state, **"Increasingly length of stay has been determined less by the characteristics of patients than by the characteristics of delivery systems."**[7]

The patients considered here generally have endured many such "long-term" treatment efforts. Others may appropriately arrive in such programs very soon after receiving a psychiatric diagnosis. The wide range of conceivable scenarios defies categorization.

The Referring Therapist

Initiating referral to a long-term program is emotionally taxing. **We may recommend costly treatment yet at the same time we recognize the inevitable, profound disruption it can induce in family equilibria and that we cannot predict the individual outcome. The therapist, patient, and family share both apprehension and recrimination.** If only our work had sufficiently facilitated ego strengthening, we think with regret. The wrenching decision to refer echoes placing a baby for adoption: vital attachments are broken in hopes that new people—strangers—ultimately will help the patient toward a more secure existence. With community resources exhausted, all involved search elsewhere for needed support.

When we send our deteriorating patient away, we challenge the very basis of our original decision to become healers. Having endured immense competitive

pressures in the course of training, we now must admit defeat, cope with self-contempt, and acknowledge, "I am a quitter." Compounding our narcissistic injury, we must telephone and then write a summary of our failed attempts, communicating them to strangers.

Almost inevitably, the therapist sending his or her patient to a long-term program has struggled chronically with anxiety, dreading some particular cluster of catastrophes. They include repetitions or escalations of past debacles.

I imagine the more powerful terrors issue from the therapist's unconscious. **Suicide or homicide attempted, much less achieved by the patient, is the stuff of a therapist's deepest nightmares.** These images can resonate with imagined lawsuits, as the clinician fears a family's vengefulness. I suspect that such fears of retaliation may often be a punishment for the therapist's unconscious hostile fantasies rather than for actual errors in judgment. The family might serve as repositories for the therapist's projections, as his or her superego struggles against dimly articulated anger directed at that patient or family.

The therapist's referral disrupts a status quo, confronting both therapist and patient with primitive notions of transforming the other person. Has the clinician brought heightened therapeutic zeal to bear, based on neurotic needs? Has that then sabotaged the gradual emergence of trust—and with it the emergence of improved functioning? **As tensions mount, the therapist may turn first to self-analysis, then to consultation or supervision, and then possibly to referral to a new setting.** Optimally, both therapist and patient will review and rework their ideas of their efforts.

As Searles teaches,

> Our "dedicated-physician" way of relating to the patient serves not only to act out our sadism toward him, but also to express our **unconscious determination to maintain the status quo—to preserve the patient's present, immature level of ego functioning in order to ensure the inflow of deniedly cherished supplies from him.** Thus, the loosening of the stalemate requires that the therapist become aware not only of his sadism and other negative feelings toward the patient, but also of his cherishing what the latter has been providing in him. . . If one examines more deeply the psychodnamics of the dedicated-physician therapist who is unconsciously devoted to preserving the status quo, one finds that he holds, at an unconscious level, split images—one an idealized image and the other a diabolized image—of himself and of the patient as well. . . . Thus the therapist's dedication becomes, as seen from this vantage point, an anxious, deeply ambivalent effort to both make contact with and keep safely at a distance the projected components of his **self."** [22]

Supervision

I strongly urge therapists to **consider purchasing supervision of their work with these most challenging patients.** Robert Langs, for some years, has offered weekly supervision over the telephone, and Harold Searles recently began this as well. The American Academy of Psychoanalysis sends a senior clinician to meet with study and peer-supervision groups: those clinicians might also provide telephone supervision. Psychodynamic long-term hospitals such as the Austen Riggs Center, Chestnut Lodge Hospital, the Menninger Clinic, and the Timberlawn Hospital keep track of their staff alumni. Consider calling them to locate someone near you who could serve as consultant, supervisor, or study group instructor.

Rather than consider oneself simply "exhausted," **one might use this challenge as an opportunity for post-residency advanced training. Learning psychodynamics is a lifelong pursuit,** one hardly satisfied in a few residency seminars or a few experiences in supervision during those clinically formative years. Fromm-Reichmann stressed the value of supervision, especially in therapy with a psychotic patient, ". . . not because of what the supervisor may have to offer, but for the very fact that the privacy of two is changed into a relationship of three."[23]

Abrupt Termination: The Therapist's Work of Mourning

As we imagine sending our patient away, we struggle with grief and with the work of resolving our own projections into the patient. Nor should we deny our relief at burdening some probably unknown fellow clinician.

> **The process of termination, with its attendant stresses, activates regressive forces. Our work may seem to crumble as we are caught up with our patient in a mutual and simultaneous regressive pull. In mourning the loss of our patient, we fear that our efforts may not be as fruitful as we had previously considered them to be. When the work is terminated *abruptly*, and when the patient has been chronically devastated by severe psychosis, the effect of termination may then seem to be total devastation of the long therapeutic effort.** The regressive pull on the therapist is severe, bringing forth his or her own primitive defenses.[24]

As a patient of mine was abruptly leaving the hospital to return home, she recalled a 10-year-old friend who had been stricken with polio. "Her mother killed her when she was in the iron lung and had nothing to live for," she said, blandly crediting her own mother with telling her. Perhaps universally, such murderousness resonates in patient, family, and therapist as the patient is referred to a long-term care facility, along with regret that we relinquish the possibility of actually committing that murder ourselves.

In each unique situation, we must confidently rely on our countertransferential reactions and their inherent validity. **Rather than feeling burdened with guilt over the intensity of our own rage, vengefulness, apathy, or disgust, we must recognize these affects as *the core issues with which the patient struggles.***

Indications for Long-Term Hospitalization

The basic indications for long-term treatment re-

main clear enough: 1) a downhill course in the face of increasingly active treatment; 2) an assessment that the patient needs a strong and enduring holding environment to facilitate psychic change; 3) an increasing probability of suicide as the patient's despair deepens; 4) escalating concerns that the patient may, amid rage or paranoid terror, cause severe injury or even death; and 5) the treating clinician's acknowledgment that his or her services, both direct and collaborative with other community services, are insufficient for the job.

Crises that occur can be of such magnitude that the family needs time and space to reintegrate itself after an assault on its self-assessment following a symptomatic act by the patient. The referring psychiatrist must process the countertransferential pulls generated by each of the family members in coming to a decision regarding referral. Keep in mind that the patient rarely "ends up" in the hospital. The account by the Editor-in-Chief of this series, Frederic Flach, entitled *Rickie*, eloquently illustrates these issues.[25,26]

Long-term hospitalization no longer implies patients remain for months or years as in-patients. The psychodynamically oriented hospital now is the hub of a wheel whose spokes stretch into the surrounding community. Often patients live at home while receiving daytime care, or live in nearby accommodations that may or may not be supervised. The institutions still are devoted to the patient over the long haul, helping establish more mature defenses against anxiety. They all offer structured rehabilitation programs, medication, and individual and family psychotherapy, with the emphases varying from place to place.

Program activities range from providing humane shelter to psychosocial rehabilitation to recovery through insight. However, the four major goals are always 1) intrapsychic change, 2) behavioral change, 3) more effective cognitive functioning, and 4) establishing a social network.

Before resorting to a long-term program, the patient should usually receive psychotherapy, with increasing frequency of sessions; medications and monitored blood levels, with consultation by a psychopharmacologist; and brief hospitalizations that involve medical and neuropsychologic evaluations, rehabilitation programs, and consultation with senior clinicians.

Usually, additional significant factors are present. The family with whom the patient resides suffers intolerable exhaustion and resentment toward the enormous burden of providing watchfulness and support. Young children may have inappropriately been drafted as quasi-mental health professionals. The patient's guilt over his or her own disruptiveness often compounds the strain. Thus, the family's needs count along with the patient's when deciding on residential treatment. As I think about the patients in my private practice, I am impressed by the large proportion who had been an oldest child in situations of chronic turmoil marked by the repeated hospitalization of a parent. Circumstances forced those oldest children to shoulder impossible responsibilities beyond their capability or authority. For example, they stood watch lest a parent yet again attempt suicide, the potential for additional murderous mayhem having been denied by the other parent. Only one of my patients now undergoing treatment recalls a mental health professional taking time to meet with her in childhood to discuss her mother's illness. In other instances, psychotic teenagers terrified their younger siblings. Recommending residential hospitalization should include a commitment to work with the patient's family on a similarly long-term basis. Once recovering, the patient will decide whether to relocate near the residential program or to return home, usually with more insight and effective social skills.

Financial Considerations

In our stormy economic climate, psychiatrists often consider long-term hospitalization fiscally impossible. Without gathering the necessary data, clinicians may superficially explore alternatives without sufficient resourcefulness and settle for less than the patient needs in spite of its availability.

Exploring the possibility of hospitalization should not stop with questions about insurance coverage. The insurance industry is not responsible for meeting all the medical needs of its customers. We join a culture of entitlement when we assume that no family should be expected to shoulder significant responsibility for care, just as they would in education and in purchasing homes, vehicles, and other costly items. Currently, the debate rages: should the private insurance sector or the public sector care for the disadvantaged?[27] Little is said about the immediate and extended family's and the community's burden, and still less about the patient's burden of responsibility.

The clinician who inadvertently forecloses definitive treatment makes a political statement, voting with the "managed care" contingent and the insurance companies, which would have the psychiatric community equate long-term treatment with custodial care or with an extravagant approach that is not "cost effective." Keep in mind that usually the daily rates in short-term programs, which form part of general acute care and university institutions, far exceed those in long-term programs. The savings come not in daily rates but in projected costs. If a patient is bent on self-destruction, the "failed suicide attempts" may lead to extremely costly acute-care hospitalizations, and chronic physical disabilities may compound the psychological ones. Successful suicides devastate the immediate families and their associates incalculably over decades and generations.

Clinicians and families must become informed consumers. Families may need legal help to obtain optimal financial backing. Changes in insurance policies occurring without informing the consumers have led to successful suits, as have denial of coverage or delays in payments. Also, the National Alliance for the Mentally Ill has become increasingly effective in moving state agencies to support the work of private institutions. Some states, such as Maryland, have begun "privatization," contracting with private organizations to care for state-referred patients.

Clinicians should encourage families to locate local people and organizations who are politically active and who could help explore funding options. They have much to teach the clinician as well. By the time long-term hospitalization is indicated, these families often have already had complex interactions with the insurance review system that have affected previous treatments.[28]

Diagnostic Categories

Severe Neuroses:

Adults suffering a neurosis rarely require long-term hospitalization, and those who do usually suffer from an underlying psychosis. Obsessional disorders not responding to psychotherapy and medication are often the crumbling defense against emerging psychosis. Unremitting depression usually unfolds in a secure setting, revealing an extensive delusional system of psychotic proportions.

As these underlying difficulties emerge, the referring physician may be plagued by self-doubts and recriminations, worrying that hospitalization produced those later problems. Far more likely, however, is that the patient finally feels safe to allow a fuller, most honest expression of his or her internal states.

Meanwhile, it is not unusual for a neurotic, self-defeating adolescent to require and to benefit impressively from long-term hospital-based treatment.

Borderline Psychopathology:

The long-term facility appears to offer special advantages in the treatment of borderline disorder. The literature refers to **the risks of regression and pathologic dependency emerging in hospitalized borderline patients.[29,30] Such regression is a far greater problem in general hospitals and intermediate-stay programs than in long-term settings.** In the hospital such patients present difficult management challenges. At first they may rage against the system, and then frantically cling to some portion of it, stirring staff conflict. Some staff members see them as disruptive and manipulative, and they recommend discharge to protect the program.

Meanwhile, the patient allows other staff members to see his or her yearning for treatment, and they may become unduly enmeshed in a rescuing countertransference. The patient often forms an intensely dependent relationship on a single individual while at the same time vitiating the efforts of others. The one "trusted" staff member may struggle with enormous anxiety, sensing that should disaster result, the blame will fall on him or her. In either case, **the long-term hospital—in contrast to the short-term facility—provides respite and a commitment to grapple with those difficulties.[31]**

Each segment of the treatment team may place a different expectation on the patient. In a setting of heightened tension, the patient's symptoms may intensify. Not infrequently, the patient may add new symptoms, echoing those of fellow patients. That leaves the short-term unit staff feeling not only useless but also powerfully destructive. The team may become more deeply divided over keeping the patient in the hospital, discharging him or her, or referring the patient to a long-term program.

The expectations placed on the *short-term team* by outside forces—the family and, increasingly, the insurance companies, their agents, the managed care companies, and the specter of lawsuits all may conspire to stir staff anxiety to the point of disruption. In a climate in which diagnostic related groupings hold sway over permissible length of stay, the patient's intense dependency impedes the apparent efficiency. Disruption of staff morale follows, often leading to retaliations.

Although residential programs experience those same intense pressures, they are still havens from the more intense pressures in short-term hospital units.[28] In long-term settings, the staff expects the emergence of disruptive patterns as an almost-necessary rite of passage. They await the abating of the storm and the gradual development of the patient's inner resources. Such programs can endure the initial regression and acting out and will not resist the patient's rapidly evolving dependency.[31]

In the long-term hospital, we have found the borderline patient to profit most from our efforts. For those with borderline personality disorders in particular, we have found a long-term stay often is the final hospitalization of a lifetime: the patient moves on, gradually, in a self-paced way to mental health with its sustaining social relationships, to work, and to raising families of their own. I recommend Betty Joseph's "Addiction to Near-Death"[32] as a classic depiction of the inner world of the borderline. **The Chestnut Lodge follow-up study of borderline disorders found 80% had a moderate to good outcome.[18,21] For our adolescent patients, an impressive 69% of parents found the hospitalization of their child to be either very or somewhat helpful,** the positive regard (not surprisingly) correlating strongly with outcome.[33]

Schizophrenia:

The patient suffering from one of the schizophrenias also has had many brief hospitalizations before arriving in the long-term hospital. After a stormy and terrifying initial breakdown, the patient often is sent to a succession of doctors. Appointments are missed, many medications are prescribed but inconsistently taken, and "noncompliance" becomes the banner word. As the patient and family despair, the patient may show signs of more probable suicidality. I recommend Pao's *Schizophrenic Disorders*[34] for a lucid description of the phases of deterioration and the phases of psychodynamic work, along with a thorough history of theories of psychodynamic treatment. Feinsilver's *Toward a Comprehensive Theory of the Treatment of Schizophrenia*[35] brings Pao's material up to date. **A feature that shines through in studies of the effects of long-term treatment is the family's assessment that the patient's downhill course has been reversed.** For example, Mattes et al.[6] noted that the relatives of patients diagnosed with schizophrenia, with or without other diagnoses, saw significantly more improvement when the patient received long-term rather than short-term hospitalized care.

From my observations at Chestnut Lodge Hospital, over the course of their stays, **many patients suffering from schizophrenia gradually feel more secure and relinquish their psychotic symptoms—occasionally completely—as they establish a relationship with their therapist and other members of their treatment team.** They live **more cohesive and comfortable lives** as they experience the world as an increasingly safe place. Usually, they eventually **develop the capacity to live outside** the immediate hospital structure. Some gradually enjoy gainful employment and the responsibilities of maintaining their own accommodations, and some go on to raise their own families. While Chestnut Lodge has changed dramatically since the writings of Stanton and Schwartz,[3] Fromm-Reichmann,[36,37] Searles,[38] and Pao,[34] their writings detail the schizophrenic process and the psychodynamic hospital's reactions to it. Additionally, Chiland's *Long-term Treatments of Psychotic States*[39] is highly informative. In the current climate, which emphasizes the biologic aspects of mental illness, these writings serve as an antidote to the antipsychological developments Reiser delineated.[40]

Sociopathy:

The long-term hospital serves as an important diagnostic tool. It helps differentiate those who are firmly oriented to malevolent and vengeful acts from those who are enmeshed in a system of projective identifications, compulsively playing a role that is ego-alien. When someone is suddenly discovered to be involved in dangerous activities and the family's status in the community is placed in danger, emergency use of a long-term program should be considered. Rather than taking an impulsive, retaliatory, punitive stance, all concerned should view the action as "mad," not "bad," and allow a hospital community, whose task is healing, to evaluate the total scene. The individual who has been using action to express inchoate feelings of rage and frustration should be forced, through containment and the expectation that he or she communicate, to grapple with putting those feelings into words.

Affective Disorders:

While the majority of patients with affective disorders are successfully managed today on an outpatient basis or via short-term facilities, a certain number may require long-term hospitalization. Persistent or frequently recurrent mood disturbances combined with serious interpersonal and environmental disruption may call for long-term care to permit extensive intrapsychic and behavioral changes to be effected but may be essential for any degree of sustained recovery.

The Informed Family

Like a competent librarian, the therapist guides families in their research efforts but should not represent him- or herself as expert in the current status or orientation of the huge variety of available programs. **The family will discover much that is new to the therapist as they shop with deliberation and organization.** Gradually, they will develop a sense of the institutions' personalities, strengths, and weaknesses. They should **match them with the prospective patient's pre-illness strengths and interests as well.**

Urge the family to seek out and read publications by staff members of the institutions under consideration. The family should **share this collected literature with the therapist.** Do not present a false veneer of hyperscholarship, as if the family would think less of you if you reveal you have not read the articles they receive. Ask to borrow them, and look them over.

Optimally, the therapist, patient, and family should work toward a consensus. If possible, family and patient should tour the prospective hospitals: they are choosing a place of residence that will affect the entire family. Often, however, the patient is too ill to assume an active role and may use passivity as a desperate defensive maneuver. If so, keep the patient informed. Perhaps he or she will indicate a preference in the final selection: honor this whenever possible. Frequently, the patient's preference is well-informed, based on what they have been told or have overheard about the various institutions. They will make thoughtful decisions but may couch them in bizarre or off-handed ways. **A patient's sense of having chosen a particular hospital, rather than being slapped into that same place, can affect the ultimate outcome enormously.**

Often, however, a crisis necessitates admission, overriding a deliberative process. Consider using a short-term unit while beginning preliminary research. A hasty, impulsive decision of long-term hospitalization usually leaves the patient feeling resentful, railroaded, and shunned—or even jailed. Almost universally, the patient is struggling with overwhelming guilt and grief, which he or she may deal with by denial and projection. It is less narcissistically painful to take an attitude of indignation and rage than to experience the impact of humiliation and despair.

Whenever feasible, patients should be permitted to tour the grounds and units, and if possible, talk with staff members at the places under consideration. Features of the conversations, the architecture and decor of the buildings, or even qualities of the atmosphere may resonate with people or places in the patient's past, stirring a sense of potential security and constructive homeyness.[41]

The process of choosing connotes autonomy, which will then facilitate treatment. The patient has chosen a particular place even if he or she is there on a legally involuntary status. The oppressive sense of victimization, whatever its reality bases, should be recognized and mitigated wherever possible.

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THESE QUESTIONS MUST BE ANSWERED FOR CME CREDIT.
PLEASE MARK YOUR ANSWERS ON THE RESPONSE SHEET.

QUESTIONS BASED ON THIS LESSON:

61. Which of the following statements about long-term psychodynamically oriented hospitalization is correct?
    A. The referring psychiatrist should often consider consulting with a knowledgeable, experienced colleague before deciding on such a course
    B. The only effect on the referring psychiatrist's emotional state is one of relief
    C. Exhaustion of therapeutic options in the present situation are never grounds to consider such hospitalization
    D. Outcome studies prove beyond a doubt the superiority of such care for neurotic disorders

62. Long-term, psychodynamically oriented hospitalization:
    A. Implies that a patient will remain "fully hospitalized" for at least two years
    B. Includes a wide variety of partial hospitalization and community-based care related to the hospital program
    C. Precludes the use of medications
    D. Specifically precludes family involvement in the treatment program

63. In searching for a suitable long-term hospital program for a patient:
    A. It's unethical to engage the collaboration of the patient's family
    B. Discourage both patient and family from visiting the proposed hospital prior to admission
    C. Increase the chances of an ultimately positive outcome by enlisting the patient's input in the selection process
    D. Never use a short-term facility to temporarily deal with acute emergencies while deciding on the final destination

THESE QUESTIONS ARE FOR SELF-ASSESSMENT ONLY. ANSWERS APPEAR BELOW.

QUESTION BASED ON PREVIOUS LESSONS:

I. Multiple-family groups can help address such issues as social isolation, stigmatization, and increased financial and psychological burdens by *all except which one* of the following ways:
    A. Providing a freewheeling forum for the expression of pent-up emotions and complaints
    B. Exposing families and patients to other families with whom they can exchange mutual aid
    C. Increasing the size and complexity of the social network
    D. Providing a forum to compare experiences and workable solutions to everyday problems

QUESTION BASED ON FUTURE LESSONS:

II. Which of the following statements about sources of harm in psychotherapy is correct?
    A. In general, therapists are too articulate and should observe the rule of silence more strictly
    B. If there appears to be a significant mismatch between the personality styles and values of patient and therapist, the therapist should seriously consider referring the patient to someone more appropriate
    C. Demonstrating warmth, support, and caring toward patients inevitably interferes with the process and should be altogether avoided
    D. In general, therapy should be painful and a favorable experience on the patient's part of the therapeutic relationship is harmful

Answers: I-A, II-B

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