Experiences of Patients Hospitalized During the Texas Mental Health Scandal

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TOPIC. *The impact of psychiatric hospitalization on children and adolescents hospitalized during the Texas mental health scandal.*

METHODS. *Content analysis of archival data and in-depth interviews.*

FINDINGS. *subjects (N = 19) voiced complaints about the stigma resulting from the hospitalization as well as lack of individual care, violations of personal boundaries, ineffectual outcomes, permanent disruption to family relations, separation from family, trauma of seeing others restrained, and being restrained themselves.*

CONCLUSIONS. *Unnecessary psychiatric hospitalization has long-term ramifications for children and adolescents in terms of self-view, family, and social relationships.*

Key words: *Child psychiatry, mental health, psychiatric hospitalization, qualitative studies*

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Little comprehensive or systematic research has been conducted on the experiences of the psychiatric hospitalization of young people (Schwartz, 1989) or the long-term memories and sequelae associated with such hospitalizations under the best of circumstances (Crespi & Ivey, 1987). Specifically, there has been no attempt to address the experiences of youngsters and families affected by the scandal involving widespread hospitalizations of patients during the mid-1980s and early 1990s at a time when the psychiatric hospital industry ran amuck and afoul of the law. This study was conducted to examine the experiences of these former patients as they look back on their hospitalizations during this time. This article (1) discusses the sociopolitical context of the scandal, (2) presents the major complaints by former patients and their families, and (3) reports the outcomes of in-depth interviews conducted with patients and families.

Background

No study results can be understood without an awareness of the greater context and some of the history within which the events under study are embedded. The events surrounding the for-profit psychiatric hospital scandal occurred during a time described by Phillips (1990) as "a glorification of capitalism, free markets, and finance" (p. xvii). Wall Street firms expanded in a newly deregulated environment, and the focus of collective corporate management narrowed to an intense profit orientation. Company and executive incentives and bonuses were based on the profit margins they generated, and the frenetic pace of financial activity was reflected in the short-term perspective adopted by top executive offices. Quarterly earnings replaced long-term strategic planning as a focus of scrutiny. Together with a nonstop pressure to produce, "too often . . . little attention [was paid] to methods employed" (Johnson, 1992, p. 237). As mass

media sources reported insider trading and other scandals, Wall Street executives denied that financial markets were infected with serious and fundamental ethical problems, attributing each emerging scandal to "just a few greedy kids" (Bruck, 1988).

America's spiritual leadership became tarnished by corruption as well, justifying a "Gospel of Prosperity" with Biblical justification for their enterprises (Reichley, 1985). Television evangelists founded vast empires and lived in luxury, flexing their political clout and influence with the Republican administration. By the end of the 1980s, however, many of them began to self-destruct amid scandalous and sensational allegations of sexual indiscretions, hush money, and misuse of church funds (Hadden & Shupe, 1988).

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Corruption and abuse of office characterized President Ronald Reagan's administration as scandals emerged at the Postal Service, Environmental Protection Agency, Federal Aviation Administration, Agriculture Department, Health and Human Services Department, Pentagon, and at least 13 other federal agencies (Johnson, 1992). In addition, ethical misconduct tainted the president's most valued associates at the highest levels of government (Johnson).

Against this background, American medicine underwent a transformation. Following the Federal Trade Commission's decision to lift the American Medical Association's ban on professional advertising in 1982, the stage was set for the onset of a commercialism that propelled medicine from a cottage industry to an immense business enterprise (Currey, 1992). The relationship between physician and patient began to shift to vendor and commodity.

During this same time, the psychiatric establishment continued to expand the categories of mental illness in the revisions of *Diagnostic and Statistic Manual of Mental Disorders (4th edition, revised* (DSM-IVR) (APA, 1994). Psychiatric labels and categories expanded from 60 in the 1952 DSM to more than 200 in the 1987 *DSM-IIIR* (Sharkey, 1994). The emergence of more effective pharmacologic agents signaled the start of the "decade of the brain," as psychiatrists established themselves as legitimate practitioners of a medical science known as biopsychiatry. Further stimulated by mandatory mental health insurance benefits in many employment situations, the stage was set for a new sector of human mind commerce.

In the meantime, the healthcare industry expanded in a climate of deregulation, encouraged by new insurance benefits and tax incentives (Gray, 1992). The growth of unregulated, investor-owned, corporate healthcare enterprises soon resulted in health care becoming the nation's second-largest industry (Sharkey, 1994). Following the joint lobbying efforts of the American Psychiatric Association and the National Association of Private Psychiatric Hospitals, psychiatric hospitals were exempted from the fiscal constraints of the federal government's diagnostic related group (DRG) reimbursement for illness care (Darnton, 1989; Strumwasser et al., 1991; Weithorn, 1988). This provided opportunities for enormous profit making by psychiatrists and investors alike (Sharkey). At a time when the nation's leaders were nonchalant and indifferent toward ethics violations, the stage was set for the newly emerging psychiatric healthcare enterprise to engage in a scandal of its own.

During hearings before the House Select Committee on Children, Youth, and Families in 1991, U.S. Rep. Patricia Schroeder (D-CO) asserted that at least 20% of the $800 billion in medical billings that the American people were charged by the healthcare industry might be fraudulent or questionable (U.S. Government Printing Office, 1992). Moreover, during these hearings the U.S. House of Representatives heard testimony about the extent of malfeasance in the delivery of mental health care.

Representatives of the General Accounting Office (GAO) reported that reviews of children's and adolescents' medical records beginning in 1990 found in one third of the cases that admissions were medically unnecessary, or the charts failed to substantiate an inpatient admission was necessary (U.S. Government Printing Office, 1992). These included admissions for environmental or social reasons (difficult family situations), admissions in lieu of incarceration in a penal institution, and admissions for diagnostic testing. Children and adolescents were prime targets for big profits because insurance companies were willing to allow adolescent patients to remain in hospitals far longer than adults. Moreover, the profit margins were greater for the healthcare facility that did not have to buy the expensive equipment necessary to operate acute care general hospitals (Darnton, 1989). Finally, hospitals often hired inexperienced, low-paid, and unlicensed personnel to provide care and counseling for the children in these hospitals and residential treatment facilities, thereby further increasing their profit margins (Bing, 1997). Unlike their general hospital counterparts, who were staffed with experienced critical care nurses with patient-to-nurse ratios of 2:1, the intensive psychiatric care units might be staffed by nurses with no psychiatric experience with a ratio of six to eight volatile patients to one staff member (Bing).

So little oversight was provided by regulatory agencies and the business of hospitalizing children was so lucrative that the large psychiatric hospital chains expanded their psychiatric facilities into new states as quickly as local law would allow (Darnton, 1989). Sunbelt states with weak regulatory oversight and a strong corporate presence were particularly attractive (Gray, 1992).

In several states deregulation and the abandonment of certificate of need legislation resulted in intense competition and an oversaturation of the market with psychiatric facilities. Allegations of psychiatric hospital fraud and abuse began to surface in the early 1990s. As media publicity and pressure from consumers and advocacy groups increased, regulatory agencies in a number of states investigated accusations of false medical claims, conspiracy to defraud, kickbacks, and fraudulent claims against the federal government's insurance plans (Kerr, 1991; Sharkey, 1994; State of Texas DHHS, 1992; Yang, 1993).

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Public hearings in Texas revealed patterns of widespread and consistent patterns of abuse (Mohr, 1996). Multiple lawsuits filed in the wake of what became known as the "for-profit psychiatric hospital scandal" included actions by major insurance companies, the U.S. Department of Justice, states attorneys general, and private attorneys on behalf of former patients and their families (Borreson, 1997; Noble, 1995; Timmons, 1994). Federal prosecutors focused their efforts on insurance fraud issues, and criminal charges were filed against psychiatrists, therapists, and hospital and corporate administrators. Despite charges of civil rights violations, however, the U.S. Department of Justice did not pursue legal actions on behalf of the former patients, leaving any further litigation to private attorneys. The largest mass tort was filed on behalf of 640 plaintiffs against a major investor-owned healthcare system, its hospitals, and 80 psychiatrists and administrators (Borreson).

In 1995, civil suits were filed on behalf of 640 former clients against individual service providers and against the corporation that ran the system. The malpractice

suits against service providers, which included psychiatrists and psychologists, were settled out of court (James R. Moriarty, personal communication, Houston, January 12, 1997). The suit against the corporation was settled for $120 million (Noble, 1995).

Methods

Qualitative methods were employed in this extensive exploratory-descriptive study. The study included research about professional staff members who had worked in these facilities and the investigation conducted by regulatory agencies. The findings from these studies are published elsewhere (Mohr, 1996, 1997; Mohr & Mahon, 1996). The portion presented in this paper concerns the former patients and their families. The study used a content analysis of archival data and reports from a multiple-case study design that employed both archival data and in-depth interviews of a theoretical (purposive) sample of participants. In addition, the principal investigator also conducted a structured diagnostic interview with each participant.

Sources of Data

The large pool of archival material within which the in-depth interviews are nested consists of 550 medical records, patient questionnaires, and interrogatories that were reviewed over the course of 4 months for the purposes of providing a broader context to the in-depth investigation. Data concerning diagnoses and length of stay (LOS) are shown in Table 1. A comprehensive medical review form developed by the principal investigator was used to review patient charts. The form included items such as (1) presence of a treatment plan; (2) information on those who participated in its development and review; (3) a review of patient rights including patient restrictions (e.g., visitor, written communication, clothing, clergy, unit, food, chair, peer, room, etc.); (4) issues regarding informed consent; and (5) queries regarding violation of personal rights, discharge procedures, and other concerns. This form was designed to corroborate answers asked by attorneys and regulatory agency personnel that were recorded on patient questionnaires and interrogatories.

Table 1. Medical Records (*N* = 550; LOS = 59.6 days)

Primary Diagnoses on Axis I	*N* (%)
• Major depressive disorder (MDD)	317 (58%)
• Chemical dependency/alcohol dependency	64 (12%)
• Bipolar disorder	63 (11%)
• Attention deficit hyperactivity disorder (ADHD)	42 (8%)
• Conduct disorder/oppositional defiant disorder	42 (8%)
• Other	14 (3%)

Table 2. In-Depth Sample (*N* = 19)

Primary Diagnosis on Axis I	*N*
• Major depressive disorder (MDD)	11
• Attention deficit hyperactivity disorder (ADHD)	4
• Atypical psychosis	1
• Substance abuse	2
• OCD	1
• LOS	
Range: 10 to 225 days	
Mean: 64.5 days	
Median; 52 days	
• Sex: 10 males, 9 females	
• Ages at time of interview	
Range: 8 to 24	
Mean: 17.2	
• Ages at time of admission	
Range: 3 to 18	
Mean: 11.5	

The in-depth interview material represents case studies of 19 individuals who were hospitalized in psychiatric hospitals owned by the same corporation from 1985 to 1991. The sample was chosen for maximal variability of factors such as age, diagnoses, length of stay, gender, ethnicity, hospital, and geographical distribution across the state of Texas. Salient descriptive information is provided in Table 2.

Procedure and Data Collection

Informed consent was procured from patients and their parents when appropriate. Written permission was obtained from all participants for charts to be reviewed by the principal investigator and the research team. The team reviewed 4,321 entries (written progress notes), individual treatment plans and treatment plan updates, and 102 assessments and consultations recorded in the charts. This was done to corroborate information on patient questionnaires, interrogatories, medical review forms, and content elicited in individual interviews.

Participants in this study (and their parents where applicable) were informed of the study's purpose, the risks and benefits of participation, and the method of data generation; confidentiality was assured. The principal investigator conducted in-depth unstructured interviews face-to-face at locations chosen by the 19 participants who for the most part chose to be interviewed at home. No time limit was imposed on participants, and the interviews were conducted until the participants (and their parents) believed they had exhausted their descriptions of the hospital experience and its sequelae. Length of interviews ranged from 3 to 6 hours (average time, 5 hours). This length of time was required because the subject matter was so affectively laden that participants spent a great deal of time alternately crying and composing themselves. This generated an enormous amount of data, only a portion of which can be presented in this paper; more will be presented in subsequent publications. Standardization of questions helped delimit the issues discussed and otherwise kept a focus on the questions that were asked. The open-ended aspect allowed the interviewer to be responsive to individual differences.

In addition to the interviews, the Psychiatric Diagnostic Interview-Revised (PDI-R) (Othmer, Penick, Powell, Read, & Othmer, 1989) was administered to each participant *after* the original interview. This structured interview was done to validate the presence or absence of certain symptoms that emerged spontaneously during the interviews. The PDI-R is a structured interview used to determine if a person is suffering or has ever suffered from a major psychiatric disorder. It is designed to evaluate 17 basic syndromes and four derived syndromes. Because it is a criterion-referenced instrument that corresponds to DSM diagnostic categories, there are no norms. Reliability measures reported include interrater, intrarater, and test-retest reliabilities. Diagnostic agreement for syndrome identification with a 6-week interval between interviews was 93%; diagnostic agreement ranged from 67% to 93%. Agreement between the PDI-R and the Diagnostic Interview Schedule (DIS) on syndrome identification was reported at 91% and was 79% on current diagnosis. The PDI-R required between 15 and 60 minutes for administration.

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Follow-up interviews and data collection were conducted with each participant at a 3-month interval using a shortened form of the original interview. The shortened form, consisting of questions based on ongoing analysis of the data, was designed to check issues of clarity and interpretation with participants. Data collection with the 19 participants took 1 calendar year.

The major questions posed were: "What was the experience of your psychiatric hospitalization as you remember it?" and "How are you doing now?" Participants' responses guided subsequent questions and the interview was geared toward gaining a clear understanding of their feelings about the hospitalization experience, the caregivers, and the interventions employed in the treatment. Related questions concerned the best

experiences they remembered from being in the hospital, the worst experiences, and some of the things that happened to them after they left the hospital.

Data Analysis

Because of the large quantity of data, several approaches to analysis were employed. The context portion of the study, derived from chart review, relied on descriptive statistics and content analysis of the in-depth questionnaires. The procedure for content analysis of archival data has been reported elsewhere (Mohr, 1997). The units of analysis in the case studies were the cases themselves. Analysis employed mixed strategies that integrated case-oriented and variable-oriented approaches (Stake, 1995; Yin, 1989).

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Strategies used in data analysis of the 19 in-depth interviews followed Colaizzi's (1978) methodological outline: (1) Audiotaped interviews were transcribed verbatim; (2) audiotapes were reviewed against the transcripts for completeness; (3) audiotapes were reviewed to develop a sense of participants' implied and expressed meanings and to intensify investigators' sense of tone, expressiveness, nuance, and sequence of events; (4) investigator reflected on participants' descriptions and checked them against what was present in the archival data; (5) significant statements were bracketed from the hard copies of interviews, and thematic content was extracted as it emerged from the data; (6) key themes were identified and supported with appropriate contextual data; pattern clarification was conducted using cross-case analysis; (7) themes were reviewed and negotiated by a research team consisting of professionals who had experience in psychiatric hospital settings; (8) study participants were contacted by telephone and asked to review thematic descriptions, validate descriptions within the themes, and validate supporting statements; and (9) themes were reconstructed within the context of each participant's individual story.

Data from the cases were coded, and the frequencies were determined. A set of codes involving two passes over the data was generated to capture key analytic constructs. A computer program—QSR NUD*IST (1995)—was used for cross-referencing and indexing. Common themes, repeatedly voiced attitudes or opinions, dissenting voices, and inconsistencies were identified. Data were systematically arranged in categories. In turn, these categories were cross-checked against the medical records, in-depth questionnaires, and interrogatories. Related events that were consistent or discrepant on minor points across all sources were retained. Those events that were widely discrepant were bracketed for future analysis and are not reported in this paper.

Trustworthiness

Scientific rigor in this study followed the criterion of trustworthiness in qualitative research, consisting of truth value, applicability, consistency, and neutrality as described by Lincoln and Guba (1985) and Sandelowski (1986). Credibility (truth value) was established by conducting the inquiry so that the categories rang true, and by having the study participants consider the exemplar material and its interpretation. Communication with study participants was ongoing. Peer debriefing by way of discussion with multiple professional colleagues in the field of psychiatric nursing enhanced credibility. Consistency was evaluated by keeping an audit trail and choosing a professional colleague at another university to conduct an audit of the author's decision and analysis processes. Transferability was assessed by providing suf-

ficient raw data to a team of professional colleagues so they were able to judge how themes had emerged.

Results

Complaints About Hospitalization

The major complaints gleaned from the patient questionnaires about their hospitalization are rank ordered in Table 3. A majority of subjects talked about the stigma of having been hospitalized affecting how others view them presently. Former patients were frightened of answering questions on applications, and many of them said they simply left this part of their lives buried. They also expressed a great sense of betrayal that former friends had abandoned them or were embarrassed or fearful of associating with them because of the questions surrounding their "normality."

Most participants also expressed anger over being subjected to the same cookie-cutter "program" as everyone else. They posited that they were unique human beings with unique situations, and they resented having to be in the same treatment groups irrespective of individual differences. Twelve-step programs came under special attack, because participants could not understand how they would benefit from such a program for occasional recreational use of alcohol or marijuana. Nor could they see the rationale of being in such programs as an "inoculation" device that would somehow preclude recreational use from becoming problem behavior.

Personal-boundary violations were the third highest category of complaint. These had to do primarily with strip searches but also to a lesser degree with monitored telephone conversations and monitored visits. Strip searches came under attack the most. Although most respondents did not elaborate on why these were so noxious, case-study participants indicated it was the insensitivity with which they were conducted. Monitored telephone calls were seen as ridiculous and were resented as an intrusion.

The efficacy of the treatment was questioned, with many respondents declaring they could see no benefit from their hospitalization, as illustrated by the quotes in category D, Table 3. In response to questions about what they found disruptive to their lives, participants were vociferous on the issue of disruption of family relations, with many of them harboring resentment against their parents for putting them in the hospital (category E). Those who spoke to family problems also shared memories of fear, separation anxieties, and dysphoria at remembering their separation at a young age from their mothers and fathers (category F).

The final two categories were concerned with either being or seeing others being restrained or isolated. The respondents described themselves as traumatized physically and psychologically both by observing and by being the recipients of this restrictive intervention. They perceived staff members as all powerful, using force as the basis for their power. There also was a remarkable lack of understanding about why these "punishments" were implemented, or how they were supposed to be helpful.

Family Involvement

When our research team analyzed responses on the questionnaires from the larger group of 550 patients, asking what their participation had been in their treatment, an overwhelming number of respondents recounted that neither they nor their parents had any involvement in decisions about their care. The treatment team meetings were not seen as a collaborative or inclusive way to communicate and negotiate care, but rather as places where decisions about their disposition were made. To substantiate this impression, the treatment plans were inspected for evidence of patient or family involvement. The results in Table 3 corroborate patient memory in that there was scant evidence for the presence of patients or family members at the treatment planning meetings. One caveat to these results is that they are based on documentation of who participated in the treatment planning, and documentation might have been poor. This reservation notwithstanding, the results underscore what patients reported on their questionnaires.

Table 3. Major Complaints About Hospitalization (Rank-Ordered)

A. Stigma (*n* = 518)
- People look at me different now.
- My family acts like [as if] I'm crazy.
- Folks treat me different.
- People feel like they have to walk on eggshells around me.
- I'm not allowed to have a bad day.
- My friends moved away [didn't want to have anything to do with me].
- When I have to answer questions on applications it spooks me.

B. Lack of individual care (*n* = 483)
- Everyone was treated the same.
- No one took into account that we were there for different reasons.
- I really resented having to be herded into the same groups as everyone else.
- My problems were a lot different than other peoples' but I still had to go to the same groups.
- No one talked to me.
- No one explained anything to me.

C. Violation of personal boundary (*n* = 478)
- It really seemed stupid to me to have someone sit there and listen to my phone calls with my mom.
- Did they really think that I was going to say something stupid with them spying on me?
- How was making me strip every time I came back from a pass supposed to help my depression?
- It just made things depressing all over again.

D. Ineffectual (*n* = 478)
- I didn't get anything out of it.
- I could have gone to out patient for a lot cheaper.
- It was a waste of my time.
- It didn't do anything for me.
- It didn't make me better.
- I had the same problems coming out as going in.
- I didn't feel any different after.

E. Permanently disruptive to family relations (*n* = 366)
- I can never forgive my parents for putting me there.
- I can't forgive my mother for lying to me.
- I've forgiven my mom, but I can never forget [that] she did it.
- I forgave my parents because I'm a Christian, but things will never be the same again.

F. Separation from family (*n* = 122)
- It made me the saddest that I couldn't see my mom.
- They wouldn't let me see my mom.
- I really missed my mom and dad.
- It made me mad that they wouldn't let me have any contact with my family.
- It was really hard being able to see my family a couple times a week.

G. Seeing others restrained or isolated (*n* = 93)
- It just kind of put a silence on everybody when that would happen.

H. Being restrained or isolated (*n* = 61)
- . . . worst thing was getting held down, that really hurt, and getting punished for things that I didn't do.

I. Other context gleaned from archival cross-comparisons
- Involved in treatment plan? Yes: 12; No: 536
- Family involved in treatment plan? Yes: 3; No: 512
- Other undesirable sequelae reported:
  A. Trauma symptoms: 524
  B. Loss of trust in professions: 407
  C. Behind in school: 311

The Sentiment Remaining

Psychic trauma occurs when a person is exposed to an overwhelming event and is rendered helpless in the face of intolerable danger, anxiety, or instinctual arousal. Trauma research indicates that children exposed to acts of personal violence, or who witness violence, experience intense hyperarousal states (Schwartz & Perry, 1994) and can develop a trauma response (Eth & Pynoos, 1985). Common features found in the child witness include the distressing intrusion of violent or mutilating imagery, the challenge to the child's own impulse control, the demanding task of assigning human accountability, and the potentially debilitating effects of unexplored revenge fantasies (Terr, 1985).

Of the 19 children chosen for the in-depth case studies, most suffered at least two or three distressing features they related to being in the hospital (Table 4). Phenomena reported surfaced from the interview process and were reported on the PDI-R. Intrusive thoughts associated with problems in concentration included those of observing "take downs"; being "taken down," placed in restraints, separated from parents; and observing behavior of fellow patients that was bizarre. The latter was reported by youngsters whose unit's census had dropped and who were placed on adult wards. (In the jargon of psychiatric facilities, a "take down" is the process of physically pulling patients to the floor and holding them down so they can forcibly be given medication or secluded and placed in leather restraints. This involves as many as seven staff members to one patient. In at least one of the hospitals owned by the corporation under investigation, some children and adolescents were known to have remained in restraints for months at a time (Noble, 1995; Smith, 1997).

Table 4. Symptoms Reported at Time of Interviews ($N = 19$)*

	$N =$
• Reexperiencing	
1. Intrusive thoughts	14
2. Recurrent dreams	10
3. Flashbacks	10
4. Trauma cue reactions (psychological)	15
5. Trauma cue reactions (physiological)	12
• Increased arousal	
1. Sleeping problems	16
2. Mood swings	17
3. Problems with concentration	17
4. Hypervigilance	4
5. Startle response	8
• Avoidant	
1. Avoids thoughts/feelings	14
2. Avoids activities/persons and places	14
3. Fails to remember	17
4. Experiences decreased interest in activities	10
5. Feels estranged from others	14
6. Has emotional anesthesia	13
7. Has trouble trusting	15
8. Has feelings of doom	0

* Not all participants reported the same symptoms

Psychic trauma occurs when a person is exposed to an overwhelming event and is rendered helpless in the face of intolerable danger, anxiety, or instinctual arousal.

Avoidant responses included examples such as the older youngsters deliberately driving out of their way to avoid the geographical area where the hospital was located. In two cases the building was no longer there, yet participants avoided the area where it had stood. Other avoidant responses involved shunning healthcare professionals in general. Respondents reported that their trust in counseling, psychology, or psychiatry had been shattered. More unfortunate was that their trust in their parents and friends had been shattered in cases when they harbored resentments at having been put in the hospital by parents or rejected by friends afterward. This is consistent with research reports that youngsters viewing an event they interpret as traumatic or violent and in which they feel helpless can leave them with profound changes in their sense of the safety and security in future human relationships. They describe themselves as "having the need to live alone in an impenetrable fortress" (Bennedek, 1985, p. 15).

Discussion

Limitations

A potential criticism may arise because the sample of former patients and their families was collectively angry

at having been in the hospital. They believed their options for least restrictive alternative had not been fully explained to them and the corporations had lured them into a *most* restrictive setting unnecessarily and for financial gain. Their anger pervaded many of their recollections. In the instances where reports seemed skewed, the principal investigator made certain they were corroborated in the medical records and on the interrogatories.

Another limitation is concerned with the archival material itself. First, medical records typically reflect an overemphasis on the negative since they are chronicles of problems. In the case of psychiatric records, they are chronicles of aberrant behaviors. Second, it is not known whether the staff members were charting to maximize reimbursement. If so, the material would be even more skewed toward the negative. There was some concern from the Texas state attorney general's office and the Texas Department of Health and Human Services that "charting for maximum reimbursement" may have indeed been the norm in investor-owned psychiatric hospitals (State of Texas DHHS, 1992).

It is difficult to understand, even given the above zeitgeist, how such massive unwarranted hospitalization of youngsters could have transpired and how psychiatrists, nurses, psychologists, social workers, and other professionals could have seemingly condoned them. Psychiatric hospitalization is a traumatic event for all concerned (Cohen, 1994). It is difficult to accept that competent professionals with a good understanding of child development and ecological theory could have rationalized to themselves and their colleagues that they were actually involved in the children's best interest. For example, attachment theory (Bowlby, 1951) would predict that psychological damage is enhanced when young children are taken out of their homes and placed in environments where there are inconsistent and undertrained staff members responsible for entire units of patients. Moreover, an ecological developmental perspective (Cicchetti, 1993) of child development posits that individual ontogenic and microsystem factors must be taken into account when treating children. These factors include enhancing buffer systems such as families by including them in treatment planning and taking into account the developmental level of the child in treatment. These are not new perspectives in child development theory.

Further, developmental psychopathologists advise that when hospitalization is unavoidable, unpleasant medical and nursing procedures should be kept to a minimum, and unrestricted visiting by parents (Rutter, 1979, 1981) should be allowed. Repeated hospitalization, particularly in children already experiencing some family adversity, is associated with an increased risk in psychosocial problems in the future (Rutter, 1979). Children may become intensely angry and adolescents become preoccupied about changes in self-image, or they may become depressed and blame themselves (Newcorn & Strain, 1992). Public labeling of children or adolescents as deviant in some way also increases the likelihood they will engage in acts consistent with the label (Rutter & Giller, 1983).

Thus, the American Academy of Child and Adolescent Psychiatry has developed the standard that hospitalization should be used only when treatment in a less intensive setting is not possible or has failed. Moreover, they recommend that patients should be placed at the least intensive and least restrictive level of care compatible with safe and effective treatment (APA, 1989).

Implications for Practice and Policy

Children very often may see hospitalization as a punishment (Rutter, 1979). When hospitalization becomes necessary, milieu interventions ideally should be aimed at increasing self-esteem, enhancing trust and motivation, and providing structure and timely positive feedback (Adams & Gullotta, 1989; Peterson, Gray, & Weinstein, 1994). Treatment also should include patient and family involvement. The time has long passed when families were viewed as causative agents in their loved one's psychopathology (Marsh, 1992). Advocacy groups such as the Alliance for the Mentally Ill encourage negotiated models of cooperative caring between professional

staffs and informal caregivers. This requires that psychiatrists, nurses, social workers, and other mental health professionals relinquish their claims to exclusive authority and expertise and recognize the expertise of the family that has had the lived experience of extensive daily interactions with the patient. Unfortunately, such collaborations are far more time consuming in the short term, and it is more "efficient" for staff members to make decisions on behalf of patients and families.

Professionals who work with children in any capacity must understand the importance of a milieu that is aimed at providing a climate of trust and safety. When children become hospitalized, the environment becomes, in a sense, a surrogate family, and nurses as well as other healthcare professionals are entrusted with the role of caretakers. As such they are often in the best position to harm (Baier, 1986) as well as to heal. Mental health professionals are responsible for managing their fiduciary role in a way that promotes healing and optimal care. It is critical that they not only recognize what constitutes a therapeutic environment, but also be able to determine the elements of a potentially destructive environment, as well as its outcomes, so they can most effectively help design health-promoting milieus and interventions. The knowledge of how families and patients experience institutional environments and their long-term effects can provide justification and sound rationale when it becomes necessary to act as patient advocates.

In mental health settings of all kinds, professionals are confronted with a wide variety of individuals. In this study, none of the people met the criteria of being highly disturbed—they were not aggressive or undersocialized, neither did they engage in antisocial behaviors. Yet medical records showed they were at different stages of development, and some were documented as having learning difficulties that necessitated an individual approach to care. Interestingly, developmental theory notwithstanding, all the children were made to go to group "therapies," which in almost all the cases were 45 to 50 minutes long. Some of the very youngest children could not remember how long the groups were, but medical records gave ample evidence of 45- to 50-minute groups. Although group therapy is a well-established and cost-effective treatment modality, it is not rational to expect a small child, especially one who is having attention problems or information-processing problems, or even acute anxiety from being in a strange place and away from his family, to benefit from a group of this length. A template program may seem like an elegant, cost-effective, and parsimonious approach to treatment. But if the program is so generic as to be meaningless, it benefits no one, except perhaps the corporation who can charge for multiple treatment modalities. Expecting the same response or outcome from every cookie-cutter intervention in every patient is simply unrealistic and nontherapeutic.

In addition, mental health professionals often are confronted with individuals who suffer from substantial symptomatology secondary to childhood trauma. Too often children who are disturbed can generate negative countertransference among staff members. Wounded children often perceive the world as hostile (Dodge, Price, Bachorowski, & Newman, 1990). They often are angry, slow to trust, and, as self-protection, may resort to aggressive behaviors seemingly without provocation. Flouting unit rules and disruptive behavior make unit management more difficult (Adler, Kreeger, & Zigler, 1983). Given enough time, a treatment milieu can be characterized by an aggression-coercion cycle in which increasing levels of aggressive and coercive behaviors are exhibited—not only by patients, but also by staff (Goren, Singh, & Best, 1993).

Studies such as these, which underscore challenges to therapeutic care, represent a reality check that asks us all to reexamine how we educate our students, how we practice, and how practice may be constrained by unsupportive environments. This research has the potential to add to the knowledge about some of the effects of unmonitored, unrestrained, and unregulated growth of marketplace medicine on individuals at a very personal level. It provides clues as to the effects of deviant environments on patients, and it documents how the institutional environment is perceived by patients. This information can be used to improve clinical practice environments.

Experiences of Patients Hospitalized During the Texas Mental Health Scandal

Finally, the study has policy implications. Testimony by state government officials (U.S. Government Printing Office, 1992) indicates that some state attorneys general were reluctant to prosecute one of the corporations involved because of the corporation's size and financial clout. In the few years since, health care has become a major service industry, with enormous economic potential and the potential to affect important health policy decisions. The growth of the for-profit hospital sector, and in particular the ever-larger integrated healthcare systems, makes it crucial that advocacy groups and policy makers work toward establishing strict oversight of the kind of care rendered by these institutions. Vaughn (1983) suggested that three factors contribute to deviant behavior on the part of big business: a competitive environment that generates pressures to violate laws, organizational characteristics that shape opportunities for deviance, and a permissive regulatory environment. There is ample evidence that all three factors were present and gave rise to this example of organizational malfeasance. In this case many tender psyches were damaged and many families torn apart in an era marked by intense pursuit of profit. In particular, when decisions made by healthcare workers can affect the future well-being of our children and adolescents, strict oversight and guidelines for any and all restrictive interventions must be clearly articulated and monitored.

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