The Psychiatric Hospitalization of Children: An Overview

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ABSTRACT: This paper reviews significant outcome studies regarding the hospitalization of latency-age children and examines pertinent admission criteria. Essential diagnostic and therapeutic components, including milieu therapy, individual therapy, family work, pharmacotherapy and school are discussed. The future role of psychiatric hospitalization of children is examined.

KEY WORDS: Latency-age, inpatient hospitalization.

The psychiatric hospitalization of school-age children has been a focus of child psychiatry for many years.[1] Traditional inpatient treatment has revolved around dynamically-oriented individual therapy,[2] usually requiring an extended length of stay. Recent changes within psychiatry have altered hospital-based treatment approaches,[3] contributing to diversity within the field regarding admission criteria,[4] models of inpatient treatment,[5,6] and lengths of stay.[7] The purpose of this article is to consolidate and present the major issues and recent literature about the hospitalization of children. Efficacy studies, criteria used for hospitalizing children and the optimal components of hospital programs are presented and discussed. A discussion of how hospitalization can serve as an important component within a continuum of mental health services for some children is offered.

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Efficacy Studies

Recent pressure from third party payors, as well as philosophical and theoretical changes within the field of mental health, have raised questions about the appropriateness of psychiatric hospitalization for children. Increased scrutiny has underscored the need for efficacy studies to determine the utility of this form of treatment. To date, twenty-nine retrospective studies have detailed follow-up status of former inpatients treated on traditional, long-term units. In addition, five recent studies examining patient adaptation following treatment on short-term inpatient units have been reported.[8]

Two short-term follow-up studies were prospective surveys measuring the effectiveness of specific inpatient techniques in the treatment of conduct disorder and antisocial behavior. LaBarbera[9] used the Devereux Child Behavior Rating Scale to assess psychological change at the time of discharge among 26 children treated for three months on a psychiatric unit. While he concluded that overcontrolled children showed some gains in social relationships, no significant change was exhibited on 13 other factors of the behavioral scale. Kazdin et al.[10] investigated the combined effects of parent management training and cognitive-behavioral problem-solving skills training for 40 children with antisocial behaviors. At discharge and one year later the study group showed significantly less aggression and externalizing behavior at home and at school than the control group. Two studies[11,12] presented demographic data concerning lengths of stay, placement at discharge and recidivism rates but did not attempt multiple case analyses. Ney et al.[13] used the Peterson-Quay Questionnaire in their retrospective analysis of 94 children and adolescents admitted consecutively to a short-term unit. Two complicating factors were that only 49% of the study population returned the questionnaires and children and adolescents could not be distinguished.

Twenty-four of the twenty-nine efficacy studies examining outcome of former child inpatients on traditional, long-term units have been reviewed by Blotcky et al.[14] Only five of the studies were prospective, eight were complicated by the inclusion of adolescents, and only two offered statistical reliability of measures. The predominant follow-up sources of data were record reviews and interviews, although nine studies used rating scales. The percentages of patients involved in the follow-up studies were relatively high although Blotcky and his colleagues suggest that this requires cautious interpretation. The findings were organized and reviewed according to patient, family and treatment variables.

Several studies have demonstrated a correlation between intellectual functioning during hospitalization and long-term outcome. Bender's[15] study underscored this correlation for autistic children, while Johnson and Rubin[16] and Lawder and Nordan,[17] using interviews, record reviews, questionnaires, and rating scales, demonstrated the relationship between intellectual functioning and long-term outcome for patients with mixed diagnoses. The presence of organicity has also been shown to correlate with poor outcome in several studies. Koret[18] used interviews, record reviews and rating scales with patients discharged six months to six years prior to the study to show that patients with the diagnosis of organic brain syndrome did worse in follow-up than those without organic findings. As Blotcky notes, the results regarding organicity are difficult to interpret because many investigators have not specified the nature of their patients' organic findings.

Diagnosis has also been correlated with follow-up adjustment. Levy[19] reported that patients diagnosed with psychotic disorders did poorly at follow-up, while those with less serious diagnoses faired better. These findings were corroborated by Lewis et al.[20] who reviewed outcomes eight to 14 years following discharge. Although they were able to obtain data on 43 of 51 children in their study, interpretation of their results is complicated by the fact that only 23 of 51 patients were actually interviewed at follow-up. Additionally, several investigators have correlated psychotic symptoms with poor outcome.[16,17,18,19,20,21] Conclusions about the correlation between diagnosis and follow-up adaptation are questionable because few investigators have specified the method of diagnosis or the specific treatment techniques used during hospitalization.

Age at admission has been correlated with long-term adjustment. Lewis[20] implied that psychiatric admission at an early age led to better long-term adjustment. In contrast, Morris et al.[22] concluded that hospitalization at an early age portended poor outcome. Dalton et al.[23] in reviewing the hospitalization of 18 preschool children, showed that the reason this age group is hospitalized is because of the severity of symptoms and lack of family and community support. In an unpublished follow-up study, they concluded that well over 50% of these patients continue to have major problems five years after discharge, underscoring a correlation between early hospitalization and poor outcome. Some studies have suggested that the prognosis for boys is better than that for girls.[22] Furthermore, many studies have correlated family functioning with follow-up and have related poor adjustment with the presence of mental illness within the fam-

ily.[17,20,23] While these results are not surprising, they should be interpreted cautiously because of the inconsistent methods used to measure family functioning.

Follow-up studies not included in Blotckey's review offer little additional information. Loff et al.[24] used questionnaires to assess consumer satisfaction with inpatient treatment. Because only 18 of the 124 returned questionnaires provided information about children, no conclusions could be drawn about this population. Doherty et al.[25] presented demographic follow-up data, but did not review patient outcome. White et al.[26] used parent ratings to conclude that no statistical relationship could be found between clinician's prognosis at discharge and patient's follow-up adjustment. Finally, Winsberg et al.[27] attempted a prospective study to measure the effectiveness of outpatient versus inpatient care. Their conclusions were obfuscated by the fact that some patients originally assigned to outpatient care required emergency hospitalization during the period of study as well as by a lack of concurrence between hospital and community raters in judging behavioral deviancy.

Overall, these studies seem to indicate that specific patient, family, and treatment variables are related to outcome and that hospital treatment for psychiatrically disturbed latency-age children is correlated with positive long-term adjustment for over 50% of patients with neurotic and character disorder problems, but fewer than 50% of patients with psychotic problems.[14] However, these studies have done little to answer pressing questions. Which hospital treatment modalities are most effective for specific complaints and diagnoses remains conjecture. Studies comparing inpatient treatment versus community-based therapy and less restrictive residential treatment have not been attempted. The efficacy of short-term versus long-term hospitalization has been largely unexplored as have issues relating to the hospitalization of preschool children.

Although it would be unethical to deny treatment to a group of patients for the purpose of establishing a control group, the current level of statistical research development allows more sophisticated, multivariate analyses than those which have been attempted. The use of standardized measures (structured interview systems, specific tests for organicity, behavioral scales, family functioning scales) as well as standardized follow-up procedures (structured interviews, rating scales) would make comparison among studies possible. Applying these approaches to patients treated in different settings (inpatient, outpatient, residential facilities, community-based programs) would

answer many of the extant questions regarding level of care needed for symptom resolution and continued developmental progress.

Criteria for Hospitalization

The importance of having clear indications for the psychiatric hospitalization of children is underscored by Stone's[28] review of the possible disadvantages of hospitalization: 1) disruption of the child's family and community relationships; 2) expense; 3) reinforcement of parental denial or guilt; 4) confused and distorted perceptions by the patient's siblings; 5) removal of the child from the continuum of the education system; 6) predictable noxious stigmata and labeling; and 7) potential for unresolved transference and dependency attachments to the institution.

Through the years, admission criteria have become more specifically defined. Bradley[29] believed admission should be considered if the child's need for an accepting environment and full schedule of activities could not be provided in the home or community. Noshpitz[30] recommended hospitalization when less intensive, less restrictive treatment programs had been tried unsuccessfully. Connell[31] later offered a more detailed set of indications: 1) the need for diagnostic work that cannot be obtained on an outpatient basis; 2) a severe disturbance within the child that precludes management within the home; 3) impaired physical status of the child that requires skilled nursing care; 4) adverse environmental circumstances that preclude the child's improvement within the home; 5) gross overprotection by parents or encouragement of invalidism after an injury; and 6) school refusal that cannot be managed on an outpatient basis. More recently, Hersov and Bentovim[32] agreed with Connell with the addition of two criteria: 1) at times when family interaction is so distorted that life at home leads to continuing or progressive interference with the child's development and progress, and 2) when specific assessment and treatment, such as a double-blind controlled trial of medication, cannot be administered as an outpatient.

These criteria can generally be divided between those calling for removal of the child from the home versus those specifying the need for hospitalization. A serious case of anorexia nervosa that has not responded to appropriate outpatient therapy usually requires skilled medical and nursing services offered in a hospital. Can the same be said of the serious behavior disorder that has not responded to out-

patient therapy? The answer, in part, depends upon what is available within the community. If there is a residential facility or group home with a reasonable staff-patient ratio that provides a consistent milieu with appropriate individual and family therapy and adequate psychiatric and psychological services, then hospitalization might not be necessary. Some would argue that a community-based approach in which a multidisciplinary team works within the identified patient's home on a daily basis, might be sufficient.[33] The ultimate decision should be based on the clinician's experiences of how effective each level of care (hospital program, residential treatment program, group home, foster care program, community-based program, outpatient therapy) within the community has been in treating specific diagnostic entities and symptom patterns occurring within preschool and school-age boys and girls living within various types of families. Future multivariate, follow-up analyses will be helpful in offering general guidelines. Currently, however, decisions should be based on the clinician's sense of how best to protect the patient's development. The importance of timely and adequate relief, the correction of early major disturbances, and the prevention of future disabilities must be considered.[28]

Program Components

Although outcome studies have not yet specified which inpatient treatment modalities are most effective with specific symptom patterns and diagnostic entities with the exception of the work by Kazdin et. al,[10] inpatient clinicians have long advocated the inclusion of certain approaches within hospital settings. The importance of treatment planning, milieu therapy, family therapy and parent training, individual therapy and pharmacotherapy, and school are discussed in the following sections.

Treatment Planning

As outlined by Dalton et al.,[34] goal setting, a clear explanation of what the patient can accomplish during hospitalization, is key to effective treatment planning. The goals are discerned after a period of assessment in which patient characteristics, symptom patterns, family and environmental contexts, developmental issues, and biological precipitants are reviewed. Specific treatment modalities designed to

achieve the goals are chosen accordingly. Discharge planning begins at admission. It focuses on what the family must do to maintain reasonable limits within the home and on the therapies necessary for the patient's continued developmental growth after hospitalization. Patients are referred to less restrictive, out-of-home placements if appropriate limits and healthy psychological development seem unlikely in the home when the patient no longer requires a hospital setting.

Chart notes reflect progress toward achieving daily therapeutic objectives as well as overall hospital goals. The treatment plan is reviewed and revised during formal staff meetings held at least weekly by members of the treatment team representing psychiatry, psychology, social work, nursing, activity therapy and school.

Milieu

The milieu (unit environment) is designed to teach appropriate interactional skills while discouraging inappropriate ones, and to provide motivation through positive and negative reinforcements and through the development of trusting, alliance-building relationships between patients and staff. A consistent routine (e.g., mealtime, awakening, bedtime, school and therapy attendance) is established and maintained.[35] Rules are readily presented and consequences for infractions are explained and applied consistently. An adequate staff-patient ratio and a positive unit philosophy maintain compliance without the need for restraints or seclusion rooms.[36] Time-out (five to ten quiet minutes sitting in the corner of the room) is used to help control impulses and process interactions. The child who refuses time-out is physically held by a care-giver until able to comply. Activity therapists use modeling, coaching, behavioral feedback and teaching during daily social skills groups to teach appropriate behavior and interactional skills.[37] Unit staff use the same techniques to reinforce the group training throughout the day. A privilege level system which positively reinforces completion of chores and cooperation while negatively reinforcing inappropriate behavior can be very important in teaching and maintaining control on the unit. When the system is applied to daily unit situations requiring predictable interactional patterns (e.g. mealtimes, community meetings, school, chores), the child's entire day becomes a compilation of therapeutic experiences.

Maintenance of a suitable balance between behavioral control and

the provision of nurturance is a major task for all children's units. The developmental needs of latency children require both empathic caregiving and the consistent application of behavioral limits.[38] Lack of consistency is often the product of either an overly zealous application of rigid rules or the refusal to apply previously explained consequences. Close supervision of the milieu is required to help maintain the appropriate balance for each patient as well as for the unit as a whole.[39]

Issues that diminish the relationship between staff and patients impede progress toward therapeutic goals.[40] Recognizing and managing potentially destructive staff issues are crucial on all children's units using alliance-building relationships therapeutically. A well-functioning milieu contains the same healing properties as a well-functioning family. A poorly maintained unit environment that ignores staff and patient feelings can be destructive. Effective supervision also monitors staff reactions to patients and to each other and helps mitigate the development of problematic interactions.

Family Therapy

Recent philosophical changes are reflected in greater family involvement during the hospital process. Authors have begun to explore theoretical approaches to family therapy and parent training programs that serve either as the main focus of the child's hospitalization or as a necessary component intergrated with others.[41] Many have advocated the use of parent groups to provide support, information about unit activities, and specific educational material designed to positively facilitate parent-child interactions. Parent training groups provide a cognitive basis for parents to understand their contributions to maladaptive interactional patterns and for the development of different, more adaptive ways to respond to their children. Behavioral child management techniques discussed in the group should be similar to those used by milieu staff. Parent Effectiveness Training (PET)[42,43] or a similarly structured training program[44] can provide the didactic foundation for the group. Laqueur[45] has outlined phases of multiple family therapy and has underscored the importance of the group process in helping parents modify previously entrenched patterns.

Few authors have addressed specific technical issues related to hospital-based family therapy. Lansky[46] underscored the differences between hospital-based family psychotherapy and outpatient family

therapy, raising questions about the application of the outpatient literature to this situation. What role directive, structural, strategic, and systems-oriented therapeutic approaches have is not entirely clear. Our experience is that the use of a structural, psychoeducational approach, after addressing assessment and alliance-building issues, is the least invasive, most efficient initial therapeutic intervention. Some families respond positively to this approach, altering ways of behaving that previously precipitated or helped to maintain the presenting complaints. For other families the lack of change becomes most obvious during family visits and therapeutic passes when the patient's problematic behaviors, previously contained on the unit, recur. A systems-oriented approach is often required to understand narcissistic vulnerabilities within the family and to help relieve family conflicts.[47-49]

Individual Therapy

Psychotherapy is an important part of the hospital process. The specific approach varies according to the patient's problems and needs as well as the therapist's orientation. Therapy within the hospital differs from outpatient work in that data about the patient is gleaned from several sources, not just from therapy sessions. As part of the team, the therapist shares information with milieu staff, group leaders, school personnel, and other unit therapists. Furthermore, the patient's primary unit relationship might not be with the individual therapist, creating potential transference and countertransference problems that are not usually extant in traditional, outpatient work. Investigators have divided the therapy process into an initial, alliance-building phase, a middle phase in which conflicts are understood and alternative behaviors sought, and a final phase in which separation issues are recognized and managed.[11,53] It is our experience that these phases vary according to the type of therapy, the patient's problems, the length of hospitalization, and follow-up plans.

Pharmacotherapy can be a necessary treatment modality used to stabilize the patient while alliance-building and other interactive approaches might be pursued.[54] Children with biological vulnerabilities toward either affective or thought disorders often require medical management in addition to other therapies.[55] The need is discussed among team members; the choice of a particular medicine is determined by the child psychiatrist. Major tranquilizers and antidepressants that prove to be effective are usually continued for three to four

months following a remission of symptoms and then tapered and discontinued if possible.

School

Successful inpatient units provide a daily school experience[56] so that patients can maintain academic progress. The school also provides an excellent opportunity to evaluate the patient's academic and intellectual skills. Behavioral responses in the classroom and to subsequent, structured homework periods offer valuable information about situations that typically precipitate untoward acting-out. School provides the treatment team with the opportunity to observe the children's reactions to poor academic performance. Because learning and school performance are primary ways in which children achieve, problems with self-esteem and depression are common among children with learning disabilities and might go unnoticed without the structure of school.

A close liaison between the unit teacher and the home-based school helps maintain the child's position within the school. Successful ways of motivating the child regarding school and useful techniques for managing problematic behaviors are discussed. The transition from the hospital back to the classroom is facilitated by this liaison.

Which particular components are most effective with specific problems awaits future controlled studies. Traditionally, there has been a split among inpatient clinicians regarding the importance of various components. Some view individual psychotherapy as the key component and see milieu work as intrusive. Others argue that there is little reason to consider hospitalization if a multidisciplinary, environmental approach is not used. Recently, the importance of family work, especially in short-term units, has been advocated. In our opinion, all of these components can be successfully integrated into a well-run unit. They will not all be equally important in the care of each patient, but will be necessary to provide effective treatment for the wide range of patients who are currently admitted to latency-age units.

Discussion

Currently, hospitalization for psychiatrically disturbed children ideally serves as the most restrictive setting within a continuum of

services including residential care, group homes, foster care, community-based assistance, and outpatient therapy. Unfortunately, the decision to hospitalize is not always based on the clinician's view of the most efficient, least invasive available therapeutic approach to help remediate the problem, but is sometimes a product of convenience, third party reimbursement, or the clinician's financial situation.[4]

It is our view that, in current practice, hospitalization should be limited to those situations that are unresponsive, or have been shown in the past to be unresponsive to other forms of therapy and other levels of treatment. The primary clinician needs to assess the individual's presenting complaints and choose a level of care accordingly. If inpatient therapy is chosen, the clinician works closely with the patient and treatment team to determine the optimal time for discharge. The clinician and team, in consultation with the parents, choose the next least restrictive level of care required for continued improvement and growth. The clinician should monitor the patient through the various levels of care until the patient no longer requires therapy.

Economic constraints and concerns by some regarding the possible misuse of hospitalization for latency-age children have contributed to greatly increased scrutiny of this treatment modality. Many question whether hospitalization will have any role in the future treatment of children. While it is difficult to know what will happen, it is clear that decisions about the future role of hospitalization need to be based on efficacy studies, not simply on emotional and economic issues. Research should be encouraged and expanded to study which symptoms, diagnoses and patient variables respond most appropriately to specific therapeutic modalities. Controlled studies comparing the various levels of care across patient, family and treatment dimensions are needed.

We think that it is unlikely, however, that psychiatric hospitalization will cease to exist for children. It is difficult at this point to imagine a level of care that could more efficiently treat psychotic patients and those with affective disorders who are in acute distress and who require skilled medical and nursing care. In our experience, however, this group does not comprise the preponderance of patients treated on latency-age units. During the past three years, approximately 50% of the patients in our university-based unit[34] and over 50% on our state hospital unit[23] have suffered primarily with behavioral disorders. Whether hospitals will continue to be important in the care of con-

duct disorders will depend on the establishment of community-based programs and smaller, more efficient residential facilities and group homes. If well-controlled studies show that they are as effective as more expensive hospitals in the treatment of symptom patterns and diagnoses related to behavior problems, then hospitals should play a much smaller role than they currently do. Well-trained clinicians would then need to organize their practices in such a way as to facilitate the use of these levels of care for their patients.

In summary, efficacy studies show that the effectiveness of latency-age hospitalization depends on patient, family, and therapy variables. Multivariate analytical research to discern which variables respond best to specific therapeutic modalities should be undertaken. While many investigators have delineated indications for hospitalization, we think that they serve, at best, as guidelines. The decision must be based on the patient's needs and the levels of care and proven effectiveness of those levels within the community. If hospitalization is chosen, the unit on which the child is treated should encompass the previously described therapeutic components.

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