Modern Aspects of Psychiatric Day Care*

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Introduction

THE BRITISH TERM, social psychiatry is synonymous with the American term community psychiatry. These terms emerge with the socio-cultural theory of mental illness. This theory, while recognizing aspects of somatic and hereditary theories of mental illness, emphasizes the influences of environments, culture and education rather than bodily trait alone. (Caplan and Caplan, 1967). Theory influences the development of new programmes. Jones (1962) and Clark (1965) described the therapeutic community or milieu therapy. Here interpersonal relationship and opportunities for increased freedom and responsibility for the psychiatric patients, form important parts of the treatment regime. The psychiatrist and his therapeutic team of trained nurses, occupational therapists, psychologists and social workers, participate in therapeutic interaction with the patients.

Introduction of chemotherapy facilitates the setting up of Day Hospitals or Day Care Centres for the management of patients in therapeutic milieu. These multiplied in Britain and United States (Farndale, 1961, Zwerling, 1966 and Bierer, 1969). In late 1960's Hospital Bahagia, with the Lutheran Church, Ipoh, and subsequently the Perak Society for Promotion of Mental Health, with the financial grant from the Social Welfare Department, initiated the first Day Care centre for psychiatric patients in Malaysia. The Psychological Medicine Unit, University Hospital, Kuala Lumpur opened a Psychiatric Day Care Centre in December, 1971. Day Care Centres are envisioned in the Second Malaysia Plan for Mental Health (Haq).

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Objective of this paper

This paper describes the functions, principles, methods and techniques involved in the management of selected patients in Psychiatric Day Care. Hopefully, interest will be stimulated in better understanding and utilization of this modality of treatment.

Functions of a Psychiatric Day Centre

Morrice (1973) mentioned the following functions: (1) Treatment of patients on day basis who would otherwise require hospital admission or very frequent out-patients visits. (2) Family involvement was recognized as important. (3) A number of patients, mainly in the older age range require support and rehabilitation rather than active treatment. Some respond to simple encouragement and social interaction.

General Principles of Psychiatric Day Care

A day centre alters the environment of a patient during a significant portion of his daily life and yet enables him to return home at night and during weekends so that he can continue interacting with his family. The process involves presenting them with relevant life situations, and in knowingly and systematically applying whatever psychological techniques are available to modify whatever maladjusted behaviour they display. (Meltzoff and Blumenthal, 1966).

The setting must offer a wide variety of psychosocial stimulus and situations to increase the chances of eliciting relevant behaviour from different individuals. This will require activities with a spread of psychological characteristics, and prototypes of real life situations.

The types of characteristics fit into examples of such dichotomies as solitary – social, self-initiated – assigned, active, – passive, verbal – non-verbal, intellectual – non-intellectual, gross-motoric – fine motoric and people-orientated – project-orientated.

Day patients are on their own and must plan for themselves and regulate their own affairs. In the capsule community represented by the treatment unit every opportunity should be given for self-determination. Patients should be given this responsibility in increasing doses when they can handle it.

The programmes and activities should adhere to a principle of realism if we are to facilitate learning and foster generalization.

A unit should be small enough in physical size and case load so that no individual is lost from view and all are well known to each other and to the staff. An atmosphere of intimacy and cohesiveness is desirable to facilitate programming, promote a feeling of unity and belongingness, and permit the carrying out of treatment plans for each individual.

Treatment Methods

They include individual, family and group psychotherapy, occupational therapy, recreational therapy, art therapy, music therapy, psychodrama, educational therapy, social case work, work therapy, chemotherapy and vocational counselling.

Underlying most of the therapeutic methods that have been cited are a number of very specific techniques of modifying human behaviour. Most of these techniques can be applied by any of a variety of trained staff, whether they be psychiatrists, psychologists, social workers, occupational therapists, nurses or others.

Any technique as well as any activity can be beneficial, inconsequential or damaging, depending upon how and when it is used.

Treatment Techniques

Differences in arrangements, timing and emphasis give distinctive characteristics to the various treatment techniques. None of these techniques are specific recipies for any particular behaviour. Use of the appropriate technique at the appropriate time for appropriate behaviour constitutes the expert skill in therapeutic intervention. The following techniques, with examples, are not mutually exclusive and more than one can be applied around the same activity.

1. *Support :* e.g. a patient felt that she couldn't make a beautiful paper flower. An occupational therapist assured her that she could and encouraged her to proceed.
2. *Direction & Guidance :* e.g. a patient was told that he would look brighter if he shaved more frequently. A few female patients were instructed on beauty care of their facial appearance. They were told directly what were the expected behaviour and outcome.
3. *Environmental manipulation :* e.g. an adolescent who quarrelled frequently with her equally nagging mother was encouraged to spend some time in Day Care as well as staying temporarily with her married sister. Her father too was relieved that there would be peace at home.
4. *Selective positive reinforcement :* e.g. staff and patients complimented a patient whenever he dressed appropriately and came neatly groomed to the Day care.
5. *Desensitization and relearning :* e.g. a patient became very anxious whenever she disagreed openly with her husband. In a joint-session with the patient and her husband, the husband assured her that no harm would occur to him nor would he assault her when she expressed her disagreement appropriately. She became less anxious when she expressed her views. She had also learned that her somatic discomfort decreased when she had a chance to clarify what her husband said and expressed her feelings.
6. *Extinction :* e.g. Undesirable behaviour may be ignored and finally stopped.
7. *Redirection and Channelling :* e.g. a delinquent was noticed to kick at a junior staff after having been reprimanded by a doctor for being uncooperative and keeping mum during a group session. The casual relationship was pointed out to him. As a means to channel his anger constructively, he was encouraged to draw the feature of the doctor on a punch-bag so that he could hit it. When this was threatening to him, he may pound some clay.

8. *Role Playing:* e.g. Interpersonal relationship, the role-relating behaviour of staff and patient, father and son, employer and employee, etc. became clearer to staff and patients when they participate actively or passively in role playing. For example, an indecisive and helpless wife, as portrayed by a patient, might be very revealing to a particular patient who 'couldn't understand' why her husband was so angry and frustrated with her.

9. *Catharsis:* e.g. A filial, soft-spoken girl from a conservative family with a dominant mother cried her heart out when an empathetic staff allowed her to narrate a particular episode. She felt relieved.

10. Interpretation is used minimally. The staff is aware that he may project the wrong motive behind a patient's action. At appropriate times, a patient who wanted to go to the toilet whenever problems of sex were discussed in a group was told of his possible discomfort about sex.

Problems and limitations

Day care management has brought hope and produced some results. But it is not the magic wand for dealing with all psychiatric problems. Selection of patients is important for its success. The acute psychotic and suicidal patients need a secured in-patient milieu. The aggressive, acting out patients tax the good-will and energy of staff and patients. (Teoh, et al, 1973) The therapeutic milieu needs external reinforcement and support, in the forms of sheltered work-shop, work therapy where the patients will be financially rewarded. This will involve people beyond the therapeutic community.

Summary

Emergence of the sociocultural theory of mental illness and introduction of chemotherapy enable the setting up of a special type of therapeutic milieu, namely day care centre or day hospital. This paper reviews the functions, principles, methods and techniques involved. Via the different types of activities and the therapeutic interaction of staff and patients, selected psychiatric patients learn new behaviour patterns in a day centre while maintaining family and community contact.

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References

1. Bierer, Joshua (1969) Innovations in Social Psychiatry. London: The Avenue Publishing Company.
2. Caplan, G. and Caplan, R. B. (1967) Development of Community Psychiatry Concepts in Comprehensive Textbook of Psychiatry, Freedman, A. M. and Kaplan H. I. (Ed.) Baltimore, Williams & Wilkins Co.
3. Clark D. H. (1965) The Therapeutic Community – Concept, Practice and Future Brit. J. Psychiat. III: 947-954.
4. Farndale, J. (1961) "The Day Hospital Movement in Great Britain", Oxford, Pergamon Press Ltd.
5. Haq, S. M., Personal Communication.
6. Jones, Maxwell (1962) Social Psychiatry. Springfield, Illinois: Charles C. Thomas.
7. Meltzoff, J. and Blumenthal, R. L. (1965) The Day Treatment Centre. Principles, Application and Evaluation. Springfield, Illinois: Charles C. Thomas
8. Morrice, J. K. W. (1973) A Day Hospital's Function in a Mental Health Service. Brit. J. Psychiat. 122: 307-314.
9. Teoh, C. L, Woon, T. H., and Sim, S. (In 1973) Some clinical Problems of a Psychiatric Day Care Centre. Med. J. Malaysia, 28:80-83.
10. Zwerling, 1. (1966) The Psychiatric Day Hospital in American Handbook of Psychiatry. New York Basic Books, Inc. Vol. III, Pg. 563-576.