

# **Kindness as the Remedy of Remedies:**

*A History of Psychiatric Mental Health Nursing*

---

**Martha M. Libster,**

**PhD, MSN, APRN-PMHCNS, APHN-BC, FAAN**



# Kindness as the Remedy of Remedies:

*A History of Psychiatric Mental Health Nursing*

---

**Martha M. Libster,**

**PhD, MSN, APRN-PMHCNS, APHN-BC, FAAN**

Golden Apple Publications Monographs

## **Psychiatric Mental Health Nursing:**

### **A History of Hope, Humility, and Health Care Reform**

History is the record of human behavior over time. It is a documentation of individual and collective experiences of suffering and hope. The history of psychiatric mental health nursing is a story of hope. For centuries, nurses have provided support, comfort, holistic care, and an enduring presence to some of the most marginalized of society—those suffering from mental illness. The way that nurses care for the patient with mental illness has changed over time. That care is a historical reflection of any given society's decisions as to who is defined as mentally ill, what environment meets the health care needs of the patient and his or her family, and the best practices and treatments. To understand mental illness, the suffering of patients and their families, and the diversity of cares and cures over time, nurses must consider the historical context for the culture that encompasses mental illness and psychiatric mental health nursing. Studying the context for psychiatric care, past and present, can help to diminish the judgment and misunderstanding that continues to surround the history of mental illness, those who suffer from it, and the development of psychiatric mental health care over time.

This monograph highlights some of the significant events and trends in nurses' endeavors to understand and cure mental illness as well as to provide scientific and creative care within a healing environment. It focuses primarily on American history, but it also includes examples from the history of psychiatric mental health nursing care from around the globe. The purpose of this monograph is to provide nurses and nursing students with a sense of what it has been like to be a person suffering mental illness and to be a nurse to those with mental illness during the past three centuries. Even though understanding of mental illness and the corresponding way in which the efforts of nurses to care for patients with mental illness may have changed and evolved over time, there is a pattern of disease that continues. Stigma surrounding mental illness and those who suffer from it endures despite its prevalence throughout history, its common place in the human experience of suffering, and the historical presence of good nurses who provide comfort, care, and hope.

### **Is There a Cure?**

The underlying question about psychiatric illness that has endured over the course of many centuries is quite simple: Is there a cure? The history of psychiatric care includes much discussion, dialog, and debate about defining psychiatric illness and disease, identifying acute versus chronic patterns of disease, and evaluating the effectiveness of cares and treatments—both short- and long-term—for those who suffer mental illness. There have been times when people with certain types of mental illness were shackled in chains to protect the community from what people have thought of as demonic possession. At other times, those with mental illness have been cared for in their community health care centers. Where, when, and how people are cared for demonstrates society's health beliefs at a given period. Historical records document those health beliefs and practices. Even though health beliefs and practices do change over time, the underlying question about the

possibility of a cure—that is, the eradication of mental illness—endures in the minds and hearts of clinicians, scientists, clients, and their families.

The research and writing of nurse-psychologist Dr. Courtney Harding exemplify the nature of the quest and nurses' important roles in finding solutions to the question of cure. Harding's work with clients with schizophrenia, well known as the "Vermont Study" (Harding, Brooks, Ashikaga, Strauss, & Breier, 1987a, 1987b), is said to be one of the longest-running studies in American clinical medical research. This study has involved the deinstitutionalization and rehabilitation of clients with schizophrenia in their communities. Sixty-eight of 82 of the chronically mentally ill clients with schizophrenia in the study significantly improved or recovered. They function as members of society. This evidence confronted previous beliefs about the poor outcomes of schizophrenia. Analyses comparing the outcomes of long-term studies by Harding and two others suggest that clients with schizophrenia can indeed move in the direction of improvement and recovery (Harding, 1988). However, people are still hesitant to use the word "cure" when referring to those who have learned to live with schizophrenia.

It is not surprising that Harding, a nurse, would persevere with persons suffering chronic mental illness in this way, study their suffering, help them and their families, and ultimately provide hope to persons with mental illness, their physicians, and their caregivers. **Perseverance** (the continued adherence to a course of action or path despite obstacles or resistance) is a trait that has defined nurses throughout time. Like Harding, Prudence Morrell, a nurse leader in the early Shaker communities, partnered with physicians to save the lives of patients deemed incurable or destined for death by medical estimation. Sister Prudence wrote in 1849 that "the great art or skill in curing up the sick and afflicted does not always depend on the knowledge of the Physician, it some times [*sic*] partly depends on perseverance," which she went on to define as one of the acts of her "conscience" in caring for others, which "would not let her give up on them" (Morrell, 1849, preface p. 1).

The writings of Matilda Coskery, a Sisters of Charity nurse renowned for her care of the insane, add to our understanding of the details of nursing history of perseverance with the insane, the chronically ill, and the dying (Box 2-1). She, like physicians of her time, wrote about the **curative point** in the care of clients. The 19th-century term *curative point* refers to a point of view in which the patient was treated as if he or she would be cured, as opposed to given palliative care. Sister Matilda wrote in her book for nurses in her community called, *Advices Concerning the Sick* about the important role of the nurse in relation to the curative point:

A small thing near the crisis of the patient, is very often the cause of death, for being at its height, & on the point of changing for better or worse, one little right matter neglected or one little wrong thing done, takes from him his last chance for recovery. This is what Drs call the curative

### Box 2-1

#### Historical Context

Prior to the 20th century, people with mental illness were referred to as "the insane." Although insanity was not openly discussed in society, the term *insanity* was considered a descriptive, rather than derogatory, term. People with what today are referred to as developmental delays were called "idiots" or said to be suffering from "idiocy."

point, and most rests in the hands of the nurse & attendants. (Libster & McNeil, 2009, p. 187)

Her medical colleague Dr. William Stokes, physician for the insane, said of Matilda and the Sisters of Charity nurses with whom he worked closely that nurses were important to the clients convalescence particularly at “critical points”:

It is at the period of convalescence, that the services of a judicious and skillful attendant are especially needed by the insane, in order rightly to lead the returning faculties into more healthy and rational channels. There is a certain dexterity and tact, which can alone be acquired by long familiarity with insanity in all its diversified shades and phases, and which enables their possessor to accomplish much good in controlling the morbid fancies of the patient, and in properly directing his thoughts, feelings, and affections. The judicious nurse and attendant will look with watchful eye for the earliest signs of recovery, and the moment the first glimmerings of right reason display themselves, will endeavor to promote the progress of improvement thus begun. . . . If neglected, they may pass away forever, and the patient speedily glide into a darkness of mind of deeper gloom than before. Patients, therefore, at this critical period, require much delicate attention. . . . They are, at this time, particularly sensible to kind words, but easily disturbed by violent impressions or painful emotions; and it is now, when an indiscreet word, an unkind rebuke, may effectually retard recovery, that all the Physician’s trust, and all his hope, rest on the judicious aid of a kind and gentle attendant. None can better appreciate than he the importance of the patient’s having, at this critical moment, a nurse of intelligence and humanity. (Stokes, 1849, pp. 8-9)

Critical and curative points represent the moment in time when nurses become the instruments of hope. Nurses, with their judicious and skillful approaches and interventions, have cared for and healed people with mental illness when members of society, and even physicians, have relegated them to chains, torture, isolation, and death.

## **Early History of Psychiatric Nursing Care**

Some of the first historical accounts of psychiatric nursing care are found in the 17th-century community records of the Daughters of Charity (DC) of Vincent de Paul in Paris, France. The Protestant Reformation had suppressed non-cloistered religious life for women, and the Tridentine decrees of the Catholic Reformation in 1563 demanded that all nuns live within convent walls. By the early 17th century, there were no Protestant communities of nurses, and Catholic leadership had denied the requests of their religious women to practice nursing. Vincent de Paul and a noblewoman named Louise de Marillac collaborated in petitioning the pope for permission to create a “confraternity” of apostolic women who, rather than residing in the cloister as nuns, would “come and go like seculars,” ministering to the sick poor and insane in their homes (McNeil, 1996, p. xvii). Louise de Marillac signed the contract for their first hospital mission on February 1, 1640, at the Hôtel-Dieu in Angers (Coste & de Paul, 1985-2008a, pp. 143a, 114).

According to Vincent, the cornerstone of the DC ministry was humility, because this virtue provided a lens for the recognition and acknowledgement of both personal talents and limits (501

Vincent de Paul to Louise de Marillac 2:164 and 37 Humility 11:46 in Coste & de Paul, 1985-2008b). Vincent and Louise instructed the sisters in community life and nursing skills, which included the spiritual values essential for service to the poor. Caring for the sick poor was a tremendously difficult task. Vincent had written of the challenges of hospital ministry to the poor in particular. He described the work by saying:

If you were to go and serve the sick, it would be in a hospital or in their own homes. If it were in a hospital, alas! Poor Brother, you would be going from the frying pan into the fire, for so many painful crosses and contradictions are encountered there that the ones about which you are complaining are nothing in comparison. The work is heavy, times of rest are short and interrupted, repugnance is certain, and reproaches and insults are frequent there. Almost all the poor grumble about things because they are never satisfied and usually complain to both the devout persons who visit them and the Administrators who are in charge of them. They even make false reports to them about those who serve them because the latter have refused them something. Those poor servants are harassed on all sides, having as many supervisors and critics as there are masters, chaplains, and persons who have some responsibility in those houses. This is what our poor Daughters of Charity find the hardest. (1537 Vincent de Paul to a Brother in the Genoa House in Coste & de Paul, 1985-2008b, p. 4:440.)

Vincent de Paul is recognized as the “director of the first hospital in France which was devoted to the treatment of the insane” (Laignel-Lavastine and Vie as cited in Flinton, 1992, p. 136). He also cared for the insane in his congregations. His firsthand experience of the emotional pain and mental suffering of those with insanity sensitized Vincent to instructing the DC in nursing ministries, which in his day included the care of galley slaves, beggars, the homeless, prisoners, and the violent mentally ill. Although he did not make light of the challenges of caring for the insane in Paris, he also conveyed to the DC that caring for the insane was an important part of their ministry. He said, “Sisters, it is God Himself who willed to make use of the Daughters of Charity to look after those poor mental patients. What a happiness for all of you. What a great grace for those Sisters engaged in this work to have such a beautiful means of rendering service to God” (Coste & de Paul, 1985-2008b, p. 10:103).

Those in religious life were part of a small subset of society not only willing and able to help persons suffering with mental illness, but also inspired and dedicated to doing so in a more humane way than had occurred in the past. Vincent de Paul demonstrated his dedication to the **humane treatment** of the insane in caring acts such as instructing that patients be served the same food as the priests and brothers (Roman 274 in Coste & de Paul, 1985-2008b, p. 211:331). As early as the mid-1600s, the DC nurses’ attention to the insane illuminated the need for vigilant social justice regarding the care of the mentally ill.

The DC pioneered asylum-based psychiatric nursing at French hospitals such as Les Petites Maisons. **Asylums** served as a point of residential care for those with mental illness, particularly those patients who exhibited violence. They endured many of the hardships still associated today with the care of the insane, particularly the violent insane. For example, Sister Nicole Lequin (1626-1703) entered the DC community in 1649 and worked at Les Petites Maisons until her death.

She was injured several times and maltreated by patients but did not show resentment. Sister Nicole was known for her calm acceptance of patients' negative behaviors. She often expressed her hope to care for the insane until the end of her life. The brief accounts of Sister Nicole's work demonstrate the way in which she also persevered with her patients. A surgeon examined a patient abandoned by an attendant who had found the patient's condition offensive; soon, the surgeon also tired of caring for him because of the offensive odor of his infection. On observing this, Sister Nicole assumed the patient's care with great devotion and attention to him. She used simple remedies that she had available—and he healed perfectly in very little time. Sister Nicole delighted in instructing her nurse companions and gave them practical lessons in dressing wounds and preparing herbal remedies for patients (Daughters of Charity, April 17, 1703). Some of the DC who served in the insane asylums of France “possessed profound pharmaceutical knowledge” (Jones, 1989, p. 378).

The French DC nurses' ministry and work in the 17th and early 18th centuries brought a new level of humanity and expertise to the nursing care of the insane patient. Later in the 18th century, physicians contributed greatly to that progress as well. In 1793, Dr. Phillippe Pinel ordered the release of insane “inmates” in Paris Hôpital Général from the chains used to restrain them in their cells. He instituted a period in psychiatric care that focused on the humane treatment of patients. Until this time, French physicians and hospital administrators had considered insanity to be a social or hereditary condition, rather than an “organic” problem related to cerebral hyperemia or hardening of the nerves. Pinel and his student, Jean-Étienne Esquirol (1772-1840), who had created one of the most successful private asylums in Paris, believed that the cause of mental illness lay in the passions of the soul and that insanity did not always affect one's ability to reason. Esquirol, however, insisted on the definitive medicalization of the care of the insane. The physician was to be the principal of a lunatic hospital; it was he who should “set everything in motion. . . . The physician should be invested with an authority from which no one is exempt” (Jones, 1980, p. 386).

Henri Rech, a physician who had studied the works of Pinel and worked with Esquirol, wrote in his book *Clinique de las Maison d'Aliénés*, that the doctor was the “moral entrepreneur” within the asylum rather than the dispenser of medical therapy (as cited in Jones, 1980, p. 386). Physicians used medical therapies such as drugs for their tranquilizing or symptomatic rather than curative effect. As moral entrepreneurs, physicians applied **moral therapy**, a system of care that stressed kindness to patients and the employment of the patient in meaningful activity. Medical treatment, such as bloodletting and drugs, was considered secondary, and therefore great importance was assigned to the quality of the attendants, nurses, and supervisors who created and maintained the therapeutic environment of the asylum and administered the moral therapy.

A half century later, exploration of moral therapy continued. England's York Retreat opened as a Quaker hospital led by Daniel Tuke and George Jepson, who, following their “Inner Light” (Stewart, 1992, p. 52), pioneered moral therapy in Britain. The York Retreat was under the control of lay therapists, rather than physicians, as was advocated by Esquirol in France until the adoption of the Lunatics Act in 1845. The Lunatics Act required that the asylum be run by a medical superintendent. Prior to 1845, Tuke and his followers believed that the “key to moral therapy lay

in the quality of personal relationships between staff and patients” in Britain (Digby, 1985b, p. 57). One did not need to be a physician to implement the tenets of what had come to be known as the successful treatment of the insane, most importantly creating a **healing environment**, one in which the patient used internal and external resources to promote healing.

## Creating Safe Healing Environments

In 19th-century America, moral treatment was defined as care that focused on the rational and emotional rather than the organic causes of insanity. American physicians, like many of their mentors in Europe, adopted moral therapy as essential in the treatment of the insane, particularly those whose disease was not related to organic causes such as birth trauma. “Insanity” was still the proper term in use during the 19th century to describe those with mental illness. *Insanity* was defined by the editor of the *American Journal of Insanity* as “a chronic disease of the brain, producing either derangement of the intellectual faculties, or prolonged change of the feelings, affections, and habits of an individual” (Brigham, 1847, p. 97). The term also was used when referring to “idiocy,” defined as the “total want or alienation of understanding” and a “defect of development of the brain” (Andrew, 1842, p. 358). Mental diseases were generally organized into four categories: mania, melancholy, dementia, and idiocy. Hallucinations occurred in the manic or melancholic patient. Suicide and “drunkenness” or “intoxication,” both of which were prevalent in 19th-century American society, were often the topic of discussions about insanity in the *American Journal of Insanity* and in professional meetings.

In his 1844 report in the *American Journal of Insanity*, Pliny Earle, superintendent physician of the Bloomingdale Asylum in New York, wrote that the causes of insanity included heredity, a predisposition in the nervous system (not in the blood, as thought by Dr. Benjamin Rush [1746-1813], whose treatment focused on bloodletting), and functional cerebral disease. Before the onset of their mental illnesses, patients were often noted to have sustained injuries or other harm from falls, masturbation (in men), fever, ill health, dyspepsia, parturition, or pregnancy and amenorrhea (in women). He also noted as possible causes of insanity chronic inflammation, such as occurred in the liver and mucous membrane of the alimentary canal when tobacco was smoked. Earle stated a belief that rheumatism and gout “undoubtedly” caused insanity due to metastasis to the dura mater of the brain. Idiocy, however, was not caused by any external influence; the person was born with the condition (Earle, 1848, p. 193).

Common moral causes of insanity included pecuniary difficulties, religious excitement, death of a relative, disappointed affection, domestic trouble, fear, anxiety. The extreme tension that resulted from “excitements” in the environment caused by such situations as the constant shifts in population and the hectic pace of urban life in particular was the focus of mental health promotion and the creation of asylums such as the Mount Hope Retreat, a hospital created and administered by Sister Matilda and the American Sisters of Charity nurses, where people could live in secluded, peaceful natural surroundings. Mount Hope was landscaped with a beautiful garden, a pond, winding walkways and a meadow where patients could exercise, rest, and “forget for a time their little pains and sorrows” (Coskery, n.d., p. 32).



Resting the mind was thought key to resolving mental illness in the 19th century, just as “reducing stress” is today. Because of this belief, some thought education to be a major contributing factor in the emergence of insanity. Spending too much time *cultivating the mind* was thought to lead to excess stimulation and therefore overexcitement, a state that threatened well-being. This belief had its roots in Dr. William Cullen’s (1710-1790) theory of disease. He wrote that all disease was due to excess or deficiency of excitability, the biological capacity to react to external stimuli (Bynum, 1994, p. 17). Common medical therapeutics that were considered “depletive” or draining of excess excitability included bloodletting and emetics, and those who suffered deficiency of excitability received stimulants such as opiates. Cullen was the teacher of Dr Benjamin Rush, who took depletive therapy to the extreme in his recommendations of repeated bloodletting.

In England after 1845, moral treatment was assimilated into the area of medical expertise. The assumption of “medical monopoly over moral as well as medical treatment was a general feature of mid-nineteenth-century asylums” in Britain (Digby, 1985a, p. 13). An editorial was printed in the 1853 issue of the new *Asylum Journal* in Britain stating that the moral system of treatment could be properly carried out only under the constant supervision and continuous assistance of a physician (as cited in Digby, 1985a, p. 113).

In America there was at least one asylum, however, where moral therapy was fully implemented by nurses—the Mount St. Vincent Hospital, which a few years later became known as the Mount Hope Retreat. As stated previously, this was the asylum owned and operated by the Sisters of Charity of Vincent de Paul (SC) under the guidance of its consulting physician, Dr. Stokes. Stokes was paid \$250 every quarter for his service (Daughters of Charity, 1847-1851). He also taught at medical schools and had his own practice, but was willing to serve as consulting physician to the SC for two reasons: He and the SC had a similar vision as to how to reform psychiatric care so that it was more humane, and the SC had developed an expertise in the care of the insane that he felt necessitated only a consulting rather than a resident physician, as was the case in the large state-run asylums.

Stokes and the SC believed that it was possible to care for the insane, even the violently insane, without restraint. In 1841, Stokes had visited the Hanwell Asylum in England, which was directed by Dr. John Conolly. Conolly was well known for his application of the moral system of nonrestraint treatment. Stokes returned to America in 1842 to his new post as physician to Mount Hope under “the inspiration of the grand ideas embodied in this new system and with an abiding faith, that a new era was destined to dawn upon the treatment of the insane in this country” (Our Growth and Progress, Stokes, 1880, p. 18). Stokes’s Eleventh Annual Report of 1853 contains some of the most vivid descriptions of the definitions of disease, the moral philosophy of the institution, and the nurses’ caring practices at the retreat.

Stokes listed the major diagnoses of patients under their care as “hereditary predisposition, family affliction and trouble, anxiety of the mind and too close application to business, ill health, intemperance, pecuniary losses and reverse of fortune, jealousy and inordinate pride, disappointment, epilepsy, and masturbation” (Stokes, 1853. p. 22).

Moral causes were more difficult to identify because people did not typically talk openly about their family member's odd behaviors. However, when the doctor and nurses at Mount Hope were called on by families and friends to help, they inspired patient confidence in their services, which Stokes stated was the "very keystone of all moral treatment" (Stokes, 1845, p. 17). Just as the name of their hospital stated, the Sisters of Charity offered people hope. They believed in the power of the healing environment, especially in the asylum created specifically for the moral management of mental diseases.

Although there are no "charts" in which the Sisters recorded daily patient care, they did keep a log that included the name and age of each patient admitted to a facility, the diagnosis, when the patient was discharged, and the outcome of care. The SC also kept community and mission records that serve as resources in the construction of historical accounts. The lengthiest and detailed of the early SC's nursing-mission records are two accounts attributed to Sister Matilda Coskery: *Cradle of Mount Hope* (Coskery, n.d.) and an instruction book for nurses titled *Advices Concerning the Sick* (Coskery, n.d. c. 1840; Libster & McNeil, 2009). These accounts provide an understanding of the human suffering that the SC and Dr Stokes experienced firsthand, all day, every day, in the care of the insane. They left the Maryland Hospital for the Insane in 1838 to start the Mount Hope Retreat after realizing that the "whole system of treatment" of the insane at the Maryland Hospital had been "radically wrong" (Stokes, 1846-1888 11-12-39, p. 18). Stokes joined Sister Matilda Coskery and the SC, who left the Maryland Hospital in 1839 because they also were unable to influence administration to make changes the SC felt were necessary for safety of patients and themselves (Box 2-2). In the early asylums, nurses lived in the hospital with the patients. Therefore, safety was particularly important for these women healers.

Sister Matilda became the Sister-Servant (head nurse) of Mount Hope. She and the SC owned Mount Hope and administered all hospital activities—an unusual achievement for women of the period. Dr. Stokes defended not only his right to serve Mount Hope as a consultant, but also the right of the Sisters to hold administrative and clinical control within their facility. At the time, medical superintendents of state asylums had started an organization that is known today as the American Psychiatric Association. Many of the leaders thought safe and effective care of the insane equated with medical dominance (Libster & McNeil, 2009, pp. 138-148). Stokes disagreed and fully supported the Sisters' right to lead the mission of reinventing the care of the institutionalized insane entrusted to their care. Dr. Stokes wrote in an institutional report:

We have endeavored . . . not only to keep pace with the advancing science in the treatment of the insane, but have earnestly labored to raise it to a higher and broader plane of service; and thus fulfill its great mission of benevolence and charity, with a rigor, which would increase, rather than diminish, with age. (Stokes, 1846-1888)

One of the biggest issues for the Sisters as they engaged in moral therapy and its foundational philosophy of kindness as the "remedy of remedies" (Libster & McNeil, 2009, p. 241) was how to safely manage violent behavior in the asylum. During the peak years of its promotion, moral treatment was aimed at engaging the mind and exercising the body.

## Box 2-2

### Nursing in a 19<sup>th</sup>-Century Asylum

In 1833, Sisters of Charity Olympia Boyle McTaggart (1802- 1869), Octavia McFadden (1813-1853), and Matilda Coskery (1799-1870) were sent to nurse the patients at the Maryland Hospital for the Insane, which was located where the present-day Johns Hopkins Hospital stands. A state inspection in 1827 had found the hospital in dire condition and in debt. Just four years after the Sisters arrived, the establishment and its equipment were partially renovated, its debts were paid, and the nursing care of the patients had improved significantly (Beam, 1837). According to the report, the SC had cared for 842 patients in 3 years. At the time of the inspection there were 74 patients and 12 "Sister-Nurses," who administered the care with the aid of two men and six assistant women.

In the 1830s, the Maryland Hospital had two areas for care. They treated diseases such as epilepsy, fever, syphilis, dysentery, typhus, gangrene, and wounds. Beginning in 1834, however, they were not allowed to admit patients with "contagious diseases." Another area at the hospital was dedicated to the care of patients with mental disorders such as mania a potu (delirium tremens), intemperance, and melancholia, as well as diseases that were referred to more generally as insanity and idiocy (Maryland Hospital for the Insane, 1834-1872, p. 1). The Sisters were also responsible for the domestic duties of the institution. The Sister-Servant collected all payments from patients and handled legal and business matters pertaining to admissions. Upon a patient's admission, she had to collect from the patient the certificate of insanity issued by the Court of Competent Jurisdiction or two physicians, except in the case of those suffering delirium tremens or drunkenness, who could be admitted as long as they furnished a certificate soon thereafter. The Sisters kept a ledger of all admissions and attended the insane under the direction of the medical attendant. They executed medical prescriptions and were to make every effort to "soothe the patient's mind." The Sisters worked with physical therapeutics, such as tea made from hops (*Humulus lupulus*), an herb that calms the nervous system. It was given hourly to patients with delirium tremens who found it hard to sleep. If the hops tea was "not sufficient to produce sleep," the Sisters might administer 40 drops of opium tincture (Medical Case Book, 1832, p. 255). The power struggles between the Sister-Nurses and the resident physician of the Maryland Hospital were not resolved; the Sisters withdrew on September 30, 1840 to forge a new path in the care of the insane, in which they would create their own place of hope: the Mount Hope Retreat.

The essential components of moral treatment included removal from one's home and former associations, respectful and kind treatment in all situations, manual labor (not a cure and best applied after achieving convalescence), religious worship on Sunday, establishing regular habits, self-control, and diversion of the mind from morbid thoughts (Brigham, 1847). Patients were assigned activities appropriate to their mental and social abilities. Interventions included conversation and recreational activities, such as sewing and taking walks. The new Mount Hope

facility enabled the Sisters to offer their patients a greater range of activities and allowed them to better manage patient behaviors, including the risk of patient escape.

Providing a safe, healing environment also required proper staffing. At the York Retreat in England in the 1840s, the ratio of nurses or attendants to patients was one to eight. Although this ratio was an improvement over previous conditions, it was still higher than at expensive private asylums, where the ratio was typically one nurse to two patients or even one to one (Digby, 1985b). The purpose of “coercive” treatment or use of restraints was to protect the patient and other patients and staff from violent behavior. However, the use of restraints needed to be weighed against the risk of creating excitement or irritation and, therefore, inflammation, which, as mentioned previously, was considered a significant contributor to insanity. Free motion was one way people believed that the body discharged its excitability. When restrained, the insane person was unable to do this. The four most common restraints in use in the 19th century were seclusion, strait-waistcoats, force, and strapping to the bed (at all four points—both hands and both feet).

The intention for the use of restraints in the Mount Hope or any facility ascribing to the philosophy of moral therapy was not to impose punishment. Restraints were a last resort to help a patient reestablish his or her self-control, that part of social conduct that was emphasized in treatment at the asylums. The Sister-Nurses at Mount Hope treated their patients as if they were rational beings; they did not reprimand them for or contradict their thoughts or feelings (Libster & McNeil, 2009). It was only when the safety of the patient, other patients, the staff, or the property was at risk that they would use coercive therapies of any kind. The Sisters were inventive when it came to using restraints and creating a safe environment for patients. In 1841, W. G. Read, who had been commissioned by the New York State Legislature to visit asylums, wrote after interviewing Sister Matilda:

[The Sisters] never *permit the infliction of blows*, nor subject their patients to the strait-jacket, which they consider extremely harassing; and which, in one case at the Maryland Hospital, (if I remember aright), nearly caused the death of a frantic sufferer, by strangulation; the collar having, by his struggles, been drawn tightly across his windpipe, in which condition he was found by the Sisters. Neither are they partial to the ‘mits,’ which they consider insecure, and therefore dangerous both for patients and attendants. When they do employ them, they prefer linen ones, as less liable to stretch than leather. The Sister tells me, patients will almost always contrive to slip their hands out of the mits, when alone, and replace them when they hear some one coming. Their most usual mode of restraining the violent is, with a sort of sleeve, invented by themselves, as I understood, and which is attached to a frock body, made to lace up behind, like a lady’s corset (Stokes, 1844, pp. 15-16; emphasis in original).

Patients were kept busy engaging in domestic labor, such as sewing and knitting; playing dominoes; attending vocal and instrumental music at social meetings; and reading books such as biography, travel, and history (Stokes, 1853). Manual labor was, for some patients, very important to relieve them of stagnation of mind and body. Stokes described the fatigue that the patient felt after working hard as the “best of opiates” (Stokes, 1853, p. 28). Moral treatment typically engaged convalescing patients in daily work in the asylum to prepare them for reentry to their own family

life. The Sister-Nurses' focus on a lifestyle for patients was in agreement with a number of physicians of the period, such as Edward Jarvis, who promoted the importance of exercise, occupation, and amusements to "keep patients' minds away from their delusions and vagaries, to calm their excitement, and raise them from their depression" (Grob, 1978, pp. 60-61).

By 1852, the work of Dr. Stokes, Sister Matilda, and the SC Nurses (some of whom were called Daughters of Charity as of the 1850 merger with the French Daughters of Charity) was acknowledged nationally. Just 12 years into their mission, Dorothea Dix (1801-1887), the renowned American reformer of prisons and mental health institutions, reported (despite being notably anti-Catholic) that Mount Hope was one of two successful facilities for the treatment of persons with mental illness in the state of Maryland (Dix, March 5, 1852). The Stokes-SC model of care for persons who were insane was based on a "law of humanity and kindness," for which Stokes determined the SC nurses were "peculiarly qualified" (Stokes, 1846-1888). In 1845 Stokes stated that the virtues of kindness and benevolence demonstrated by the SC nurses at Mount Hope in the care of the insane were the "direct emanations and blessed fruits of that enlightened and universal charity which they so beautifully illustrate by their lives" (Stokes, 1846-1888, p. 25).

## **The Challenges of Providing Care**

Some have judged the early nursing care of the 19th century in light of the practice of medicine at the time. Doyle wrote for the *American Journal of Nursing* in 1929, "It is reasonable to suppose that it was very simple, and was confined to procuring cleanliness, nourishment, and safety for the sick, and the administration of simple medication. Thus, the work of the sisters was confined to the kitchen, the laundry, supervision of the wards, and taking care of the spiritual welfare of the patients" (Doyle, 1929, p. 781). However, the work of early nurses, such as the French DC Nurses and the American SC who followed in their footsteps 200 years later, was anything but simple. The SC created healing environments wherever they went. They cared for patients dying from cholera in makeshift "tent" hospitals without the benefit of modern plumbing. Caring for people with cholera, a disease characterized by excessive diarrhea and often rapid death and ministering to the bereaved families of so many during an epidemic would certainly not have been "simple" physically, emotionally, psychologically, or spiritually. Caring for those with mental illness, even when surrounded by Mount Hope's natural beauty and walls of protection, was challenging, just as it had been since the 17th century.

Insanity occurred among the poor and rich alike, but the poor were more publicly visible. The destitute insane occupied the almshouses of major American cities. Many others were cared for in state asylums that often housed hundreds to thousands of inmates. The 19th-century-American state asylum was a significant improvement on the previous options of entering the almshouse or "wandering aimlessly in community" (Grob, 1994, p. 102).

It was the reform of the state asylums and almshouses that caught the attention of women activists like Dix seeking to exercise what was socially perceived as the inherent virtues of their gender. Nurses in state and private asylums dealt with the growing national civil liberties issues surrounding commitment of an insane patient to an asylum (Applebaum & Kemp, 1982). Influential physicians of the Association of Medical Superintendents of American Institutions for

the Insane promoted early hospitalization of the insane as a means of achieving better outcomes (Grob, 1966). However, there was also a growing public concern about the need for setting limits on admissions to protect the vulnerable insane, their civil liberties, and their dignity from families and physicians who would potentially misuse commitment power (Grob, “Rediscovering Asylums,” in Vogel & Rosenberg, 1979, p. 140).

The responsibility for commitment of a person to an asylum in the early and mid-19th century usually rested with family and friends. Asylum care was typically sought for patients and families in crisis, when the behavior of the insane person grew beyond the capacity of the family or friends to manage. Nurses and physicians such as Sister Matilda and Dr. Stokes frequently referred to the importance of the freedom of the patients within the confines of the asylum’s secure environment. They used restraint only in severe cases when it was necessary to keep patients from hurting themselves or others. Wrongful confinement, about which the public was growing increasingly concerned, was antithetical to moral therapy, the hope for healing, and the possibility of a cure.

## **Progress in the 19th Century**

Throughout the 19th century, infectious diseases and epidemics, such as cholera and yellow fever, as well as social ills such as poverty and war, challenged the mental health of people and communities. Nursing care of those with emotional and mental health challenges was under development and reform in many countries. Florence Nightingale (1820-1910) of England was instrumental in introducing education for becoming a “trained” nurse to women of all classes who would care for the sick. She worked to reform care in workhouse infirmaries and change the administrative structure of the care of the insane in those workhouses and other large institutions. One example of Nightingale’s health care reforms was her advocacy for the separation of the “sick, insane, infirm, & aged, incurable, imbecile, & above all the children from the usual pauper population of the Metropolis” (Letter to Edwin Chadwick, 9 July 1866, Nightingale, Vicinus, & Nergaard, 1990, p. 271).

Nightingale herself struggled with depression and invalidism, one of the most prevalent mental health concerns among 19th-century women (Box 2-3). Invalidism particularly affected those of higher social class, as working women could not afford to be invalids (Verbrugge, 1988). Nightingale took to her bed after leading a group of nurses to provide nursing care at the Barrack Hospital at Scutari in Turkey during the Crimean War.

### Box 2-3

#### Florence Nightingale on Invalidism and “Chattering Hopes”

“Chattering Hopes” may seem an odd heading. But I really believe there is scarcely a greater worry which invalids have to endure than the incurable hopes of friends. There is no one practice against which I can speak more strongly from actual personal experience, wide and long, of its effects during sickness observed both upon others and upon myself. I would appeal most seriously to all friends, visitors, and attendants of the sick to leave off this practice of attempting to “cheer” the sick by making light of their danger and by exaggerating their probabilities of recovery. The fact is, that the patient is not “cheered” at all by these well-meaning, most tiresome friends. On the contrary, he is depressed and wearied. . . . To nurses I say—these are the visitors who do your patient harm.

[Source: Nightingale, F. (1860). *Notes on Nursing: What It Is and What It Is Not*. London, UK: Harrison, pp. 139-145.]

Attention to the emotional and mental well-being of patients is foundational to nursing care, especially in times of great chaos such as war and pestilence. In addition to Nightingale, other women earned notoriety as nurse leaders during the chaos of the Crimean War. Mother Mary Jane Seacole (1805-1881) of Haiti raised funds for her own nursing mission to the Crimea. Clare Moore accompanied Nightingale to the Crimea as her valued assistant because of her nursing expertise in “careful nursing,” a 19th-century model of nursing care developed in Ireland by Catherine McCauley and the women of the Institute of Our Lady of Mercy. Although it is not documented specifically as a model for the care of the insane as Sister Matilda’s *Advices Concerning the Sick*, careful nursing was another early contribution to holistic psychiatric mental health nursing. It specifically emphasized attention to “emotional consolation provided from a spiritual perspective” as foundational to nursing care (Meehan, 2003, p. 100). The early Sisters of Mercy demonstrated the importance of “relieving the distress first” and then endeavoring “by every practicable means to promote the cleanliness, ease, and comfort of the patient” (as cited in Meehan, 2003, p. 100). Clare Moore and the Sisters of Mercy taught their tradition to Nightingale and many others.

Nightingale herself designed a training model for nurses, which was adopted in the later part of the 19th century in emerging American “training” schools. Nightingale had little formal training in nursing but did receive some mentoring in nursing from the Daughters of Charity of Vincent de Paul in Paris, with whom she stayed on two occasions prior to her trip to the Crimea. She wrote, “There is nothing like the training (in these days) which the Sacred Heart or the Order of St. Vincent gives to women” (Letter to Henry Manning, 15 July, 1852, Nightingale et al., 1990, p. 59). In addition to the instruction she received from Clare Moore and the Daughters, Nightingale was also influenced in her nursing work by a visit in 1851 to a German hospital known as the Institution of Kaiserswerth (Nightingale et al., 1990, p. 54).

A European predecessor of Nightingale, Amelia Sieveking of Hamburg, Germany, who was called to care for the sick poor in 1830, also adopted the Vincent de Paul “model for setting about her special duty” (Sieveking & Winkworth, 1863, p. 182). During the 1831 cholera epidemic, Sieveking worked in a temporary hospital. She was approached in 1837 by Pastor Fliedner of

Kaiserswerth to accept a position as head nurse for his hospital. She declined, but later met with Fliedner in 1843, when she recommended one of her students for a position he was trying to fill. That student became Fliedner's second wife and a worker at the institution. Sieveking had missions in Germany beginning in 1852, and ultimately created an "Association" of nurses, which she named the Protestant Sisters of Mercy.

In 1873, the Nightingale model for creating the "trained" nurse was adopted in the United States. In 1882, a movement for the specialized training of asylum workers was led by Dr. Edward Cowles, who established a formally organized program at the McLean Asylum in Waverly, Massachusetts. Cowles is known to have removed bars from the windows and unlocked the doors of asylums. He moved the focus of nursing care from "attendance" upon the "incurable and infirm" to "nursing the sick to promote recovery" (Maranjian Church, 1987, p. 110). In the history of nursing, one way that professional nurses can be differentiated from "attendants" is by their education or training. Early formal education for nurses was vocational in nature and was conducted by the religious communities who stressed that nursing care include the spiritual as well as the physical needs of the sick, poor, and insane (Libster & McNeil, 2009). As nursing training moved away from being the sole domain of religious communities in the later 19th and early 20th centuries, it has been psychiatric nurses in particular who have continued to value the nursing tradition of providing holistic care (Tuck, Pullen, & Lynn, 1997), which includes attention to the emotional, mental, and spiritual needs of clients.

## **New Dimensions in Care**

In the 20th century, new dimensions in mental health care, medical science, and nursing influenced plans of care. The evolution of 20th-century psychiatric nursing, as in previous centuries, paralleled the changes in medical care and society. Psychiatric care moved away from its focus on the healing environment and moral therapy toward seeking a greater understanding of the biological and chemical bases for mental health and illness.

After the Civil War in the United States, physicians and hospitals served less as consultants to the nurse educators and experts who had traditionally found strength in religious community to mentor and train nurses in their scope of practice. Hospital committees and physicians such as Cowles took it upon themselves to create or partner with emerging programs to establish programs in which the emphasis of training would often end up reflecting the needs of the institution and physicians first and foremost. Nurses, who were not part of a religious community and who wanted formalized training, participated, as they lacked organization and sociocultural power in the public sphere. In 1906, members of the American Medico-Psychological Association presented papers on the values of training asylum attendants and nurses. "Implicit in the issues was the need for involvement of the medical superintendents in the training that was offered" (Maranjian Church, 1987, p. I 16). The association was first formed in 1844 as the Association of Medical Superintendents of American Institutions for the Insane. The name was changed in 1892 to the American Medico-Psychological Association and, ultimately, to the American Psychiatric Association (APA) in 1921. In 1907, the association-appointed group of five physicians determined that the major function of the asylum nurse was "assistance to the physician in the care and treatment of the insane" (Maranjian Church, 1987, p. 118). They also deemed that the



education of the nurse be the same as that of the physician but differing in “degrees,” thereby negating centuries of distinct definitions of scope of practice for nurses and marking the official appropriation of control of practice of mental health nursing by the association.

Echoes of bio-medicalization of nursing could be heard in Europe as well. In Dutch asylums, psychiatrists established a new system of mental health nursing that led to the reorganization of nursing care around controlling patient behavior by somatic therapies. Psychiatrists assumed that psychiatric symptoms would vanish as a result of body-oriented treatments. Nurses spent more time in assistance in medical observation and treatment (Boschma, 1999b, p. 142). The biomedical focus on providing care that was “science-based” and the creation of physician-led specialized training for asylum nurses at the turn of the century did not serve to “give nurses their own professional identity, but rather reinforced the supremacy of medical knowledge in the care of the mentally ill” (Chung & Nolan, 1994, p. 226). Part of the reason for the strain on identity had to do with gender roles. Most nurses continued to be female and most physicians male.

When moral therapy was prevalent, attendants and nurses might be male or female. In the 20th century, as patients began to receive somatic care, many were prescribed bedrest as treatment. The change in care at asylums in the Netherlands, for example, meant that women nurses were more likely to be the providers of care (Boschma, 1999a, p. 14). Later in 20th-century America, nurse leaders stated that limitations on the role of men in nursing had “disappeared” (Peplau, 1989, p. 18). Some might disagree, but psychiatric-mental health nursing has been one field in nursing in which men have most often thrived. For example, Dr. Phil Barker, a British psychiatric nurse, is well known internationally for his professional leadership in creating the Tidal Model of care, a philosophical approach to what Barker termed “the discovery of mental health.” For more information about the Tidal Model, please visit its website.

The medicalization of care and interest in psychopathology served to separate mind from body, as evidenced in the separate training programs for asylum nurses. Nursing’s relationship with medicine at the time tended to pull it away from its heritage in holistic care, as represented in such models as careful nursing and moral therapy. In 1939, the *American Journal of Nursing (AJN)* published an article on “Modern Psychiatric Nursing” in which the author-physician wrote that many nurses, like the public, had “false conceptions that mental patients are raving maniacs, lack intelligence, are weak, stupid, or often dangerous people to be around” (Bennett, 1939, p. 397). He called for every nurse to have “some psychiatric nursing experience in order to overcome misconceptions and personal prejudices against the neurotic and mental patient” (Bennett, 1939, p. 397).

Only 30 years later, *AJN* published an article interviewing nurse leaders from the American Nurses Association’s committee to establish standards for nursing practice, in which psychiatric nurse Gloria George demonstrated the strengthened role of psychiatric care in nursing and the place for advanced practice in nurse-psychotherapy. She stated that the nurse practices individual, group, and family psychotherapy and clarified that although every nurse works with families and groups, “We know that not every psychiatric nurse is going to be practicing formalized therapy” (American Nurses Association, 1969, p. 1462).

In 1913, nurse-educator Effie Taylor of the Phipps Clinic at Johns Hopkins Hospital, and later professor of psychiatric nursing at Yale University, sought to integrate mind and body once again in her nurses' training program involving general and mental health nursing. The Mental Health Act of 1946 legitimized the role of the nurse to include what is now known as psychiatric-mental health nursing and released it further from medical domination. This shift away from medicine occurred as there was a concerted effort to move care of the mentally ill from the asylum to the community. The National Institute of Mental Health was created in the late 1940s. In the same decade, members of the APA, including the Menninger brothers, who had founded the Menninger Clinic and Sanitarium in Kansas in 1919, worked to reform and reorganize psychiatry. Much of the controversy surrounding reform had to do with the role of the federal versus state government in the care of the mentally ill. In the 1940s there were a number of changes in the American health care system, including the development of the third-party payer system. The National Mental Health Act of 1946 supported research into the causes and treatments of psychiatric disorders, the training of providers, and the support of states in creating treatment facilities.

As the support for research grew in the 1950s, some believed that psychotropic medications made it more possible to modify and alleviate symptoms of severe and persistent disease, such as schizophrenia. Chlorpromazine, or Thorazine, was the first of the psychoactive drugs created. It was followed by the "tranquilizer" drugs—*Rauwolfia serpentina* alkaloids, or reserpine. The antidepressants imipramine and iproniazid emerged after that. Despite many historical references to the significant impact of the major tranquilizer medications such as Thorazine on patient outcomes, mid-20<sup>th</sup>-century nurses, as well as many psychiatrists, were not completely enthusiastic. Nursing history reveals that nurses of the time reported that the introduction of these medications did not necessarily lead to greater benefit to patients than the previous sedatives used, and they allegedly made more work for nurses (Harmon, 2005).

Nurses were engaged in many effective modalities in the care of the mentally ill. For example, **hydrotherapy**, water applications also known as "water cure" in the 19th century, was considered foundational to good nursing care for centuries, particularly in the 20th century, as care moved from an emphasis on moral therapy to more somatically based models of care (Box 2-4).

Psychodynamic care, focused on the psychological forces underlying human behavior, was popular in the 1950s when Hildegard Peplau (1909-1999) published one of the most significant works of 20th-century psychiatric nursing, *Interpersonal Relations in Nursing*. **Her interpersonal relations theory** emphasized the nurse-client relationship as *the* foundation for practice. In the book, which served as the "conceptual frame of reference for psychodynamic nursing," Peplau defined all nursing—not just psychiatric nursing—as a "significant, therapeutic process." She held two guiding assumptions: "The kind of person each nurse becomes makes a substantial difference in what each patient will learn as he is nursed throughout his experience with illness" and "Fostering personality development in the direction of maturity is a function in nursing and nursing education; it requires the use of principles and methods that permit and guide the process of grappling with everyday interpersonal problems or difficulties" (Peplau, 1952, p. xii). Peplau's work on interpersonal relations and on anxiety became foundational to nursing practice in general

and psychiatric-mental health nursing in particular. More recently, some have observed that the success of generalizing interpersonal theory to all nursing in midcentury may have ultimately set the stage for challenges in differentiating psychiatric-mental health nursing as a specialty practice area (Olson, 1996).

#### **Box 2-4**

##### **Hydrotherapy**

Hydrotherapies—including cold wet sheet applications (“humane sheets”), continuous tub therapy, wraps, and packs found often today in healing spas and resorts—were used regularly in the care of agitated, anxious, nervous, manic, hyperactive, and “deeply disturbed” patients. Hydrotherapy was viewed as a “modern, technological alternative to sedatives, barbiturates, and the more invasive sterilizations, shock therapies, and lobotomies popular in state hospitals during the time” (Harmon, 2009, p. 493). Baths used for sedation were at skin temperature of 92°F. One nursing textbook of the time describes the effect of a tub bath: “A bath at body temperature produces no marked changes in the body, wither thermic or circulatory, but surrounds it with a medium that shields it from all external stimuli, or irritation of nerve endings from air, clothing, pressure, changes in temperature and the like. As a result, the nerve centers and the whole nervous system are protected and allowed to rest. The bath is therefore soothing and quieting in its effects and gives a chance for repair and the storage of vital energy” (Harmer& Henderson, 1939, p. 475).

Peplau’s work was a reflection of the climate of care in nursing during the 1950s and 1960s, when the psychiatric nurse’s role was expressed as “extending the therapeutic process into the ward environment by creating nurse-patient relationships that promote emotional growth” (Gregg, 1954, p. 851). During the period, there was also a “re-discovery” of moral therapy and creating a healing environment as “milieu therapy.” In the 1960s, nurse reformer Esther Lucille Brown’s now-historic report on patient care identified the importance of using the physical environment for therapeutic purposes and “restoring the amenities of the era of Moral Treatment” (Brown, 1961, p. 127). She also stressed the importance of the nurse’s role in social therapy, discussing such interventions as taking meals with patients, a practice stressed by Sister Matilda more than a century earlier. From these historical patterns, we realize that treatments and scientific beliefs and ideas come and go over time in psychiatry and psychiatric-mental health nursing, reflecting the ebb and flow of human life. Indicative of that flow, hospitals for the mentally ill, for example, are no longer the “prisons” they were for centuries—but now, in the 21st century, hospitals for the mentally ill are closing and the burden of responsibility for care has moved back to the community and families.

Continuing today from the later 20th century, nurses have been taking the lead in their communities in the care of those with mental illness. With the support of nursing organizations such as the American Psychiatric Nurses Association, nurses are re-establishing their autonomy as demonstrated in the emergence of advanced practice nursing (APN) roles. APN roles in psychiatric nursing include the Clinical Nurse Specialist and Nurse Practitioner. Peplau reported that, by 1956, there were already 28 master's programs in advanced practice psychiatric nursing (Peplau, 1989). Today's psychiatric-mental health APNs provide therapy, medication management, and consultation-liaison services. Nursing scientific theories, such as *Modeling and Role-Modeling* (Erickson et al., 1983) and *Health as Expanding Consciousness* (Newman, 1994) are examples of frameworks for advanced psychiatric nursing practice. New models of nurse-psychotherapy care, such as brief solution-focused therapy, have been shown to be economical and effective (Montgomery & Webster, 1994). New specialties have emerged to meet societal needs, such as Sexual Assault Nurse Examiner (SANE), Forensics, and Infant Mental Health. Suffering from mental illness endures today, as does the hope for cure. What also endures is the nursing profession's commitment in communities throughout the world to bring hope to those suffering mental illness and their families through quality, holistic care.

## Highlights of Psychiatric Mental Health Nursing History

Throughout history, nurses have played a crucial role in providing and improving psychiatric-mental health care. As early as the 17th century, the Daughters of Charity were pioneering asylum-based care and sought and provided more humane treatment to patients with mental illness.

1. The Vermont Study is one of the longest running studies in American clinical research. It confirms the possibility of restoring patients with mental illness—schizophrenia, in particular—to a point of wellness and functionality.
2. Perseverance is an essential trait of psychiatric mental health nursing.
3. The “curative point” refers to a point of view or attitude of treating the patient as if he or she can be cured, as opposed to providing palliative care.
4. Developed in the 19th century, moral therapy is a system of care that stresses kindness to patients and employment of patients in meaningful activities.
5. The Mount Hope Retreat stands as an early example of the power of independent nursing care and the importance of nurses in the development and reform of mental health care.
6. Florence Nightingale, an advocate for those with mental illness, was instrumental in introducing a model for educating the “trained” nurse.
7. Careful nursing was a model of nursing that emphasized “relieving the distress first” of the patient.
8. First formed in 1844, the American Psychiatric Association is responsible for establishing guidelines for care for patients with mental illness.
9. The need for nurses to have education and experience in psychiatric-mental health nursing has long been recognized and documented in the literature.
10. The introduction of psychotropic drugs and psychodynamic therapy in the 20th century are two critical advances in psychiatric-mental health care.
11. Hildegard Peplau’s interpersonal relations theory emphasizes the nurse-client relationship as the foundation for practice. She defined *all* nursing practice as a “significant, therapeutic process.”

## Suggested Test Questions

1. The nurse educator is discussing the role of the nursing profession in reforming the care of persons suffering from mental illness. Which contribution supports the use of nursing research to enhance client recovery outcomes?
  - a. **Harding's work with deinstitutionalized clients**
  - b. Dix's exposé of the conditions of asylums and prisons
  - c. Coskery and colleagues' identification of curative and critical points
  - d. Taylor's training of nurses at the Phipps Clinic at Johns Hopkins Hospital
  
2. The student nurse is researching moral therapy for a leadership project. Which historical development in this system of care best represents a major evolution in the role of nurses in caring for the mentally ill?
  - a. The logging of patient information in paper records
  - b. The founding of the American Psychiatric Association (APA)
  - c. **The administration and management of care at Mount Hope**
  - d. The assignment of domestic duties at the Maryland Hospital for the Insane
  
3. The nurse is assessing a patient with mental illness. The patient reveals a history of mental illness documented in family records dating back to the late 1800s. The client notes that certain ancestors' conditions were rarely discussed or acknowledged in family communications. The nurse recognizes which social/historical variable as most likely contributing to this finding?
  - a. **The shame and stigma of mental illness has endured for centuries.**
  - b. Mental health disorders had not yet been characterized or studied.
  - c. Laws have always protected the privacy and dignity of the mentally ill.
  - d. The impact of mental illness on families during that time period was not as significant as it is today.
  
4. The psychiatric-mental health nurse is working with patients receiving treatment for mental illness. Which contemporary interventions are comparable to those employed under principles of moral therapy? Select all that apply.
  - a. **Treating all patients with dignity and respect**
  - b. **Providing activities that enable patients to remain productive and engaged**
  - c. Imposing coercive techniques to extinguish future violent or aggressive outbursts
  - d. Treating patients in the context of their family, community, and home environments
  - e. **Working to ensure a safe environment through appropriate staffing ratios and restraint reduction initiatives**

5. The nurse is completing a history and assessment of an older adult patient with a history of chronic schizophrenia. The nurse learns that the patient began receiving treatment in the 1960s. The nurse understands that the patient would be most likely to have been exposed to which types of psychiatric interventions common to that era?
  - a. Physical therapies, “curative point” approach, convalescence
  - b. Asylum treatment, depletive therapies, insulin shock therapy
  - c. **First-generation antipsychotics, milieu therapy, rehabilitative care**
  - d. Herbal remedies, palliative care, decreased emphasis on interpersonal relationships
  
6. The psychiatric-mental health nurse is providing education to the community about the importance of improving mental health services. A colleague questions the nurse’s rationale for incorporating a historical perspective of mental illness into teaching. Which response is best?
  - a. “The history of mental illness is fascinating. Providing these details may stimulate interest in the topic.”
  - b. “Nurses have had a key role in reforming the care of the mentally ill. Highlighting these facts will help to establish my credibility as a nurse.”
  - c. **“The historical context of mental illness explains the culture and beliefs that surround it. Sharing this information may diminish bias and judgment.”**
  - d. “We have come a long way in our understanding of mental illness. It is important for people to know how cures were developed for these conditions.”
  
7. The nurse is working on the planning board of a new community mental health center. A member of the board asks the nurse why it is essential to incorporate nursing care into the client treatment model. Which response best reflects an accurate evaluation of the nursing role in the cultivation of healing environments for patients with mental illnesses?
  - a. “Nurses have always been ready to care for vulnerable populations. The nursing profession is the only one that has always put client needs first.”
  - b. “Mentally ill clients have always required comprehensive medical care. Nurses have the technical skills to assess and respond to these needs.”
  - c. “Changes in reimbursement have made it possible for nurses to take on advanced practice roles. Nurse providers are likely to reduce the cost of care.”
  - d. **“Nurses have played an essential role in the compassionate care of the mentally ill. Today’s nurses have the specialized training and expertise to respond to a variety of human needs.”**

## References

- American Nurses Association. (1969). Establishing standards for nursing practice. *American Journal of Nursing*, 69(7), 1458-1463.
- Andrew, T. (1842). *A Cyclopaedia of Domestic Medicine and Surgery*. Glasgow, Scotland: Blackie and Son. Accessed at GoogleBooks.com

- Applebaum, P., & Kemp, K. (1982). The evolution of commitment law in the nineteenth century. *Law and Human Behavior*, 6(3/4), 343-354.
- Beam, R. M. (1837). *Report of the Committee on the Maryland Hospital to the Legislature of Maryland*. Maryland State Archives, Annapolis, MD.
- Bennett, A. E. (1939). Modern psychiatric nursing. *American Journal of Nursing*, 39(4), 395-400.
- Boschma, G. (1999a). The gender specific role of male nurses in Dutch asylums: 1890-1910. *International History of Nursing Journal: IHNJ*, 4(3), 13-19.
- Boschma, G. (1999b), High ideals versus harsh reality: A historical analysis of mental health nursing in Dutch asylums, 1890-1920. *Nursing History Review: Official Journal of the American Association for the History of Nursing*, 7, 127-151.
- Brigham, A. (1847). The moral treatment of insanity. *American Journal of Insanity*, 4(1), 1-15. Archives of the American Psychiatric Association.
- Brown, E. L. (1961). *Newer Dimensions of Patient Care Part I: The Use of the Physical Environment of the General Hospital for Therapeutic Purposes*. New York, NY: Russell Sage Foundation.
- Bynum, W. F. (1994). *Science and the Practice of Medicine in the Nineteenth Century*. Cambridge, UK: Cambridge University Press,
- Chung, M. C., & Nolan, P. (1994), *The influence of positive thought on nineteenth century asylum nursing*. *Journal of Advanced Nursing*. 19(2). 226-232.
- Coskery, S. M. (n.d.). *Cradle of Mount Hope: Historical Account of Mt. St. Vincnt Hospital/ Mount Hope Retreat*. Emmitsburg, MD: Archives of the Daughters of Charity, St. Joseph's Provincial House. #11-2-39.
- Coskery, S. M. (n.d. c, 1840). *Advices Concerning the Sick*. Emmitsburg, MD: Archives of the Daughters of Charity, St, Joseph's Provincial House.
- Coste, P. C. M., & de Paul, V. (1985-2008a). *Regulations for the Sisters of the Angers Hospital* (Vol. 13b). New York, NY: New City Press.
- Coste, P. C. M., & de Paul, V. (1985-2008b). *Saint Vincent de Paul: Correspondence, Conferences, Documents*. New York, NY: New City Press.
- Daughters of Charity. (April 17, 1703). Remarks on Sister Nicole Lequin. *Circulars and Notices*, 2, 554. Emmitsburg, MD: Archives of the Daughters of Charity, St. Joseph's Provincial House.
- Daughters of Charity. (1847-1851). *Mt. Hope Receipt Book*. Emmitsburg, MD: Archives of the Daughters of Charity, St. Joseph's Provincial House. 11-2-39:4.
- Digby, A. (1985a). *Madness, Morality, and Medicine: A Study of the York Retreat, 1796-1914*. New York, NY: Cambridge University Press.



- Digby, A. (1985b). Moral treatment at the Retreat, 1796-1846. In W F. Bynum, R. Porter, & M. Shepherd (Eds.). *The Anatomy of Madness* (Vol. II). London, UK: Tavistock Publications, pp. 52-72.
- Dix, D. (1852, March 5). Memorial of Miss D. L. Dix to the Hon. The General Assembly in behalf of the insane of Maryland. Archives of the State of Maryland website: <http://www.msa.nid.gov/>
- Doyle, A. (1929). Nursing by religious orders in the United States: Part 1, 1809-1840. *American Journal of Nursing*, 29(7), 775-786.
- Earle, P (1848). On the causes of insanity. *American Journal of Insanity* 4(3), 185-211. Archives of the American Psychiatric Association.
- Erickson, H., Tomlin, E., & Swain, M. A. (1983). *Modeling and Role Modeling*. Prentice-Hall.
- Flinton, M. (1992). *Louise de Marillac: Social Aspect of Her Work*. New York, NY: New City Press.
- Gregg, D. E. (1954). The psychiatric nurse's role. *The American Journal of Nursing*, 54(7), 848-851.
- Grob, G. (1966). The state mental hospital in mid-nineteenth century America: A social analysis. *American Psychologist*, 21(6), 510-523.
- Grob, G. (1978). *Edward Jarvis and the Medical World of Nineteenth-Century America*. Knoxville, TN: University of Tennessee Press.
- Grob, G. (1994). *The Mad Among Us: A History of the Care of America's Mentally Ill*. Cambridge, MA: Harvard University Press.
- Harding, C. M. (1988). Course types in schizophrenia: An analysis of European and American studies. *Schizophrenia Bulletin*, 14(4), 633-643.
- Harding, C. M., Brooks, G. W., Ashikaga, T., Strauss, J. S., & Breier, A. (1987a). The Vermont longitudinal study of persons with severe mental illness. I: Methodology, study sample, and overall status 32 years later. *The American Journal of Psychiatry*, 144(6), 718-726.
- Harding, C. M., Brooks, G. W., Ashikaga, T., Strauss, J. S., & Breier, A. (1987b). The Vermont longitudinal study of persons with severe mental illness, II: Long-term outcome of subjects who retrospectively met DSM-III criteria for schizophrenia. *The American Journal of Psychiatry*, 144(6), 727-735.
- Harmer, B., & Henderson, V. (1939). *Textbook of the Principles and Practice of Nursing* (4th ed.). Retrieved at the University of Colorado Health Sciences Library. New York, NY: Macmillan.
- Harmon, R. B. (2005). Nursing care in a state hospital before and during the introduction of antipsychotics, 1950-1965. *Issues in Mental Health Nursing*, 26(3), 257-279.

- Harmon, R. B. (2009). Hydrotherapy in state mental hospitals in the mid-twentieth century. *Issues in Mental Health Nursing*, 30(8), 491-494.
- Jones, C. (1980). The treatment of the insane in eighteenth and early nineteenth century Montpellier: A contribution to the prehistory of the lunatic asylum in provincial France. *Medical History*, 24, 371 -390.
- Jones, C. (1989). Sisters of Charity and the ailing poor. *Social History of Medicine*, 2(3), 339-348.
- Libster, M., & McNeil, B. A. (2009). *Enlightened Charity: The Holistic Nursing Care, Education and Advices Concerning the Sick of Sister Matilda Coskery, 1799-1870*. Naperville, IL: Golden Apple Publications.
- Maranjian Church, O. (1987). The Emergence of Training Programmes for Asylum Nursing at the Turn of the Century. In C. Maggs (Ed.). *Nursing History: The State of the Art*. Kent, UK: Aspen Publications.
- Maryland Hospital for the Insane. (1834-1872). *Patient Register*. Maryland State Archives, Annapolis, MD, S184.
- McNeil, B. A. (1996). *The Vincentian Family Tree*. Chicago, IL: Vincentian Studies Institute.
- Medical Case Book. (1832). Baltimore Infirmary. *Maryland State Archives, MSA SC 4070*. Tull Collection, Annapolis, MD.
- Meehan, T. (2003). Careful nursing: A model for contemporary nursing practice. *Journal of Advanced Nursing*, 44(1), 99-107.
- Montgomery, C. L., & Webster, D. (1994). Caring, curing, and brief therapy: A model for nurse-psychotherapy. *Archives of Psychiatric Nursing* 8(5), 291-297.
- Morrell, P (1849). *A Choice collection of medical and botanical receipts: Selected from experienced Physicians by whom they have been proved and found useful in the various disorders and infirmities for which they are prescribed. To which is prefixed remarks and observations for the consideration of physicians and nurses among Believers*. Winterthur Library Shaker Manuscripts, Winterthur, DE.
- Newman, M. (1994). *Health as Expanding Consciousness*. National League for Nursing Press.
- Nightingale, F (1860). *Notes on Nursing: What It Is and What It Is Not*. London, UK: Harrison, pp. 139-145. Accessed at GoogleBooks.com
- Nightingale, F, Vicinus, M., & Nergaard, B. (1990). *Ever Yours. Florence Nightingale: Selected Letters*. Cambridge, MA: Harvard University Press.
- Olson, T. (1996). Fundamental and special: The dilemma of psychiatric-mental health nursing. *Archives of Psychiatric Nursing*, 10(1), 3-10; discussion 11-15.
- Peplau, H. (1952). *Interpersonal Relations in Nursing: A Conceptual Frame of Reference for Psychodynamic Nursing*. New York, NY: G. P. Putnam & Sons.

- Peplau, H. (1989). Future directions in psychiatric nursing from the perspective of history. *Journal of Psychosocial Nursing and Mental Health Services*, 27(2), 18-21,25-28.
- Sieveking, A. W., & Winkworth, C. (1863). *Life of Amelia Wilhelmina Sieveking from the German edited with the author's sanction*. London, UK: Longman, Green, Longman, Roberts, & Green. Accessed at GoogleBooks.com
- Stewart, K. (1992). *The York Retreat: In the Light of the Quaker Way*. York, UK: William Sessions Ltd.
- Stokes, W. (1844). First Annual Report of the Physician of the Mount Saint Vincent's Hospital for 1843. *Mount Hope Reports*. Emmitsburg, MD: Archives of the Daughters of Charity, St. Joseph's Provincial House. 11-2-39.
- Stokes, W. (1845). Second Annual Report of the Physician of Mount Hope Hospital (Late Mount St. Vincent's) for 1844. *Mount Hope Reports*. Emmitsburg, MD: Archives of the Daughters of Charity, St. Joseph's Provincial House.
- Stokes, W. (1846-1888). Report of the Mount Hope Institution Near Baltimore. Emmitsburg, MD: Archives of the Daughters of Charity, St. Joseph's Provincial House.
- Stokes, W. (1849). The sixth annual report of the Mount Hope Institution near Baltimore, for the year 1848. *Mount Hope Reports*. Baltimore, MD: John Murphy & Co. Archives of the Daughters of Charity, St. Joseph's Provincial House. Emmitsburg, MD.
- Stokes, W. (1853). The eleventh annual report of the Mount Hope Institution near Baltimore. Baltimore: John Murphy & Co. Archives of the Daughters of Charity, St. Joseph's Provincial House. Emmitsburg, MD.
- Stokes, W. (1880). 38th annual report of the Mount Hope Retreat. Baltimore. Emmitsburg, MD: Archives of the Daughters of Charity, St. Joseph's Provincial House.
- Tuck, F., Pullen, L., & Fynn, C. (1997). Spiritual interventions provided by mental health nurses. *Western Journal of Nursing Research*, 19(3), 351-363,
- Verbrugge, M. H. (1988). *Able-Bodied Womanhood: Personal Health and Social Change in Nineteenth-Century Boston*. New York, NY: Oxford University Press.
- Vogel, M. J., & Rosenberg, C. E. (1979). *The Therapeutic Revolution: Essays in the Social History of American Medicine*. Philadelphia, PA: University of Pennsylvania Press.