

## AVOIDING EXTINCTION: SUCCESSFUL PRIVATE PSYCHIATRIC HOSPITALS IN THE OPENING DECADE OF THE TWENTY-FIRST CENTURY

**Jeffrey L. Geller, M.D., M.P.H.**

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The history of the private psychiatric hospital has been characterized by the rise and demise of scores, if not hundreds of facilities. In recent years some well known, long-standing psychiatric hospitals have closed their doors. What has accounted for the ability of some of the private psychiatric hospitals to flourish? Two strategies are proposed: 1) progressive change through a broadened scope and a geographic spread, and 2) staying true to the institution's core mission with clinical and fiscal modifications at the perimeter of that mission. A case example is provided for each adaptation: Sheppard Pratt Health System (Baltimore) for the former; Austen Riggs Center (Stockbridge, Massachusetts) for the latter.

**KEY WORDS:** private psychiatric hospital; history.

Jeffrey L. Geller, M.D., M.P.H., is Professor of Psychiatry, University of Massachusetts Medical School, Worcester, Massachusetts.

Address correspondence to Jeffrey L. Geller, M.D., M.P.H., University of Massachusetts Medical School, Department of Psychiatry, 55 Lake Avenue North, Worcester, MA 01655; e-mail: jeffrey.geller@umaasmed.edu.

In reviewing the history of private psychiatric hospitals in the United States (1), it becomes clear that many have both opened and shut. In the last decade, a not insignificant number of established private hospitals, often parts of multi-hospital proprietary chains, could not survive (1-3). More surprising, long-established private hospitals of excellent reputation, such as Chestnut Lodge (Maryland; founded 1910), the Institute of Pennsylvania Hospital (1752), Highland Hospital (North Carolina; 1904) and Timberlawn (Texas; 1917) also closed their doors (1,3). Others, such as McLean Hospital (4,5) and Butler Hospital (6,7) have adapted, survived, and even done well.

What has accounted for the ability of some of the private psychiatric hospitals to not only survive, but to flourish? In this paper, through the case study method, I examine two distinct strategies: 1) progressive change and community integration to move from a single, freestanding private psychiatric hospital to a broad based—both geographically and programmatically—operation; and 2) sticking to an institution's long-standing core mission with sensible modifications, reflecting ever changing clinical and fiscal realities at the perimeter of that core mission. The example chosen for the first is the Sheppard Pratt Health System; for the second is the Austen Riggs Center.

### **SHEPPARD PRATT HEALTH SYSTEM**

Moses Sheppard, a member of the Religious Society of Friends and an individual influenced by Dorothea Dix, secured a charter for an asylum in Maryland in 1853. Sheppard, who died in 1857, stipulated "that it is the Income, not the Principle of the Estate that is to sustain the institution." This delayed the opening of the institution for four decades. The first patient was admitted to the asylum on December 6, 1891. The average number of patients in 1892 was 20. The first superintendent, Edward N. Brush, adopted the humane ideas of treatment from the York Retreat, advocated for voluntary admission<sup>^</sup> and admitted patients at reduced rates and some without charge. He served 25 years (8).

Enoch Pratt died September 17, 1896 and made a bequest to the Sheppard Asylum of greater than \$1.5 million. His bequest had the stipulation that the name of the asylum be changed to the Sheppard and Enoch Pratt Hospital (Sheppard Pratt). That was done. By 1902, the average daily census was 100 patients. Over the first 20 years, the facility admitted 2,369 patients of whom 188 patients were admitted more than once. The average length of stay was eight months (8).

At the turn of the century, the facility was broadening its scope by building cottages, embarking on nursing education, employing hydrotherapy, increasing leisure opportunities, and focusing on occupational therapy. Around the years of World War I, the hospital was short-staffed due to the war effort and began attending to military neuropsychiatric disabilities. Sheppard Pratt actively supported the mental hygiene movement of that era. In 1918, the average daily census was 122 patients (8).

In 1920, Ross Chapman became Superintendent and Physician-in-Chief and served until 1948. Harry Stack Sullivan came to the hospital in 1922 and served there seven years. Individual psychotherapy was introduced to the facility in 1926. That year, the average daily census was 145 patients; by 1931 it was 254 patients (8).

During the Depression, the hospital counted on its garden, farm and dairy to contribute to its upkeep. By 1938, the average daily census had risen to 281 patients. After the Great Depression, the hospital became active in research. It further advanced its ability in nursing training and developed an excellent record system to facilitate research (8).

Around the years of World War II, the facility again lost staff due to the war effort. The staffing shortage led patients to have to assist in the running of the facility with patients often doing what staff had done previously. The two sexes continued to be kept strictly separate. In 1942, the average daily census had decreased to 260 patients. After the war, from 1946 to 1949, the hospital ran at a deficit each year. In 1949, there was a major reorganization with a renewed emphasis on psychotherapy (8).

By 1955, the average daily census had decreased to 215 patients. In 1954, Sheppard Pratt was one of the first hospitals in the United States to use both chlorpromazine and reserpine. The hospital discontinued the use of insulin coma and decreased its reliance on ECT. Increased advertising was instituted to attract patients. In 1958, the hospital expanded by creating a Child Guidance Clinic. In 1959, Lawrence Kubie, a major figure in the American psychoanalytic movement since the 1930's, joined the staff (8).

In the 1960's, Sheppard Pratt began an open staff model. Robert Gibson joined the staff as Clinical Director. From 1960-1965 deficits continued; from 1966-1970 a balanced budget was achieved each year. In order to fill beds the hospital began to increase the admissions of long term treatment cases; a geriatric center was also created. In 1963, Gibson became Medical Director and in 1965 he became responsible for the complete administration of the hospital. Patients began to be given more freedom as regulations and restrictions were relaxed.

Adolescents began to be admitted with greater frequency. In 1965, 75% of the admissions were voluntary (8).

In the period 1967-1968, 95% of the patients received individual psychotherapy; 38% received some form of psychotropic medication; 1.7% received ECT. Eighty percent of the patients were discharged home and 80% had some form of insurance. There were 27 psychiatric residents in training (8).

New programs were created at the end of the 1960's. In 1967, the hospital established a Department of Research and a Child Day Care Program for emotionally disturbed young school-aged children. In 1969, the hospital established an adult day care program, and in 1970, a Psychiatric Emergency Service and Crisis Intervention Clinic (8).

In the early 1970's, in response to the escalation of regulatory agency requirements and the resultant reams of paperwork, Sheppard Pratt developed new information systems. As had occurred in the 1960's, adolescent admissions continued to rise. By 1976, close to 27% of admissions were accounted for by persons 19 years old and younger. The expected length of stay for this population was 6-12 months. In 1972, Sheppard Pratt was acknowledged by the American Psychiatric Association (APA) for its community outreach programs, some of which were actual outpatient clinics, others of which were community service programs to colleges, schools and police departments. By 1977, the hospital's varied inpatient and community programs served an excess of 4,300 persons. At the end of the 1970's the occupancy rate was running 94—97%. The hospital, however, began to suffer from declining federal and state funding (9).

In the early 1980's, Sheppard Pratt reported itself to be financially secure. It was rocked, however, by severe cutbacks in coverage by certain third party payers. In 1985, Sheppard Pratt received 2 million dollars from the state of Maryland for the Education Center of Sheppard Pratt (9). In September 1986, Steven Sharfstein arrived as Vice President and Medical Director. At *the* time, the facility was licensed at 322 beds; the average daily census was over 300; there was a waiting list for admissions; there were 1,000 inpatient admissions a year with 90% of Sheppard Pratt's revenue coming from inpatient hospitalization; and the average length of stay was 73.5 days. That year, 92% of the payor mix was private, mostly from insurance, and 8% came from Medicare. Also at that time, Sheppard Pratt was the only private psychiatric hospital sponsoring a private community mental health center (10).

In 1992, Sharfstein became Sheppard Pratt's fifth director. He was greeted by a budget which was annually losing over \$5 million in a

revenue stream of \$50 million (10). In Sharfstein's assessment, radical surgery was needed. For one thing, he focused on rapidly decreasing the length of stay. Psychodynamic assessments were no longer possible. But most importantly, Sharfstein transformed a hospital predominantly dependent on inpatients to what was to be called the Sheppard Pratt Health System. By the late 1990's, half of the inpatient beds had been closed. The length of stay had decreased to just over eight days, and the number of admissions was five times what it had been in 1986. Only 40% of the revenue of a total \$120 million now came from inpatient sources that included not only the main hospital, but other general hospital units that the health system managed. Sheppard Pratt was treating 40,000 individuals at 26 different sites throughout Maryland. In five wholly owned affiliates throughout the state, the health system provides outpatient treatment, rehabilitation and housing to nearly 1,000 individuals with severe and persistent mental illness. The health system not only manages eight general hospital psychiatric units, but staffs their emergency rooms, in a system that provides inpatient treatment for crisis stabilization, acute safety, and assessment and treatment of complex patient diagnoses. The health system continues its training and research missions (10).

In a further move to diversify and create other funding streams, and in part in response to the closure of Chestnut Lodge (Maryland) in April 2000, Sheppard Pratt created the Retreat, a six-bed upscale unit where patients pay \$1,500 per day out of pocket for no less than 20 days of treatment. Housed in a renovated 19th-century building, the unit is described by Sheppard Pratt's vice president of corporate business development as looking "more like a bed and breakfast than an inpatient unit" (7). Sheppard Pratt hopes to generate \$330,000-\$400,000 profit from this component of the operation in order to subsidize less profitable programs (7).

In fiscal year 2004, Sheppard Pratt had a net revenue of \$153.9 million and an operating gain of \$2 million. It accounted for 15% of all psychiatric hospitalizations in the state of Maryland exclusive of state-sponsored hospitals. Sheppard Pratt completed a \$90 million construction project, the centerpiece of which is the replacement of its one-hundred-year-old hospital building with a new facility of 192 all private patient rooms (11).

In 2004, Sheppard Pratt provided inpatient treatment at nine locations throughout Maryland; partial hospital/intensive outpatient at seven locations; crisis assessment at nine locations; outpatient and/or CMHC services at eight locations; respite and/or residential services at 10 locations; and psychiatric rehabilitation at nine locations. Further,

Sheppard Pratt provided inpatient and partial hospital services at one location in Virginia, Sheppard Pratt provided an array of specialty services including an eating disorders program, geriatric program, trauma disorder services, child and adolescent programs and dual diagnosis services. Sheppard Pratt has truly evolved into a multi-campus, multi-location, full-service psychiatric center of excellence.

Sheppard Pratt advertises regularly in such publications as *Psychiatric Times*. The advertisement informs the reader that Sheppard Pratt: 1) "has been ranked one of America's best hospitals for mental health for 11 consecutive years"; 2) is "a comprehensive training and treatment center offering a full continuum of services for children, adolescents, adults and the elderly in every diagnostic category"; 3) offers a "seamless continuum of treatment" and provides ten examples; and 4) is "a not-for-profit behavioral health system." What the advertisement does not say is what Sheppard Pratt has become and what Sharfstein himself has said a private hospital must be: "Today's private hospitals ... must operate as integral parts of their community if they are to remain viable entities offering effective treatment services" (12).

### THE AUSTEN RIGGS CENTER

Austen Fox Riggs came to Stockbridge, Massachusetts in 1907 seeking a rural environment to aid in his recovery from tuberculosis. During 1907 and 1908, Riggs made several visits to John George Gehring in Bethel, Maine to observe this physician's treatment of patients. Gehring's influence led Riggs to establish a neurosis treatment center, a facility distinct from a psychiatric hospital, and subsequently labeled "a new event in medicine" (13). Psychotherapy was formally organized in Stockbridge as of 1913; the corporation, The Stockbridge Institute for the Study and Treatment of the Psychoneuroses, for the Treatment of Nervous Disorders and Such Other Charitable Work as may be Incident Thereto" was established January 21, 1919.

Riggs essentially headed the facility until his death in 1940. A physician, who used transference (which he called "rapport") as a fundamental treatment vehicle (13), he had little use for Freud—"we heartily disapprove of any method of treatment which stresses the sex instinct or unduly encourages self analysis" (14). Rather, Riggs believed that "nervousness is the result of an inefficient use of a structurally good body-mind machine, such inefficiency giving rise to maladaptations which are in turn manifested by any number of symptoms" (15). Riggs believed in a strict daily schedule with the "intensive study of

adaptation" and a program of "reeducation" (14). His theories and prescription for an institution are well spelled out in his publications in the 1920's( 14-16).

The foundation treated 5300 patients in Stockbridge, between 1910 and 1934. Of those, 68% were female. Sixty percent of the females and 54% of the males were between 25 and 45 years old at the time of admission. As the years progressed, the lengths of stay became progressively longer (13). But Riggs was interested in far more than inpatient treatment for those who could afford it. During his tenure he established a community clinic, a social service department in a general hospital and a child guidance clinic in Pittsfield, and a mental hygiene clinic in Great Barrington, to meet the needs of the residents of Berkshire County. These facilities were established for persons "known to their family physicians to be basically sound, but unable to make satisfactory adjustments to life" without regard to ability to pay (13,17). While outpatient services outside of Stockbridge are no longer a part of what is now called the Austen Riggs Center, these early clinics evolved into what is now a large, multiservice, free-standing, nonprofit community mental health center serving southern Berkshire County.

Between 1940 and 1947 the Foundation went through a series of leaders and hard times. By 1947 the Foundation was in debt and was treating only 15-20 patients due to there being insufficient staff to treat more. On September 1, 1947, Robert P. Knight arrived from the Menninger Clinic to become the new Medical Director of the Austen Riggs Foundation (18). Known for his "special techniques of psychotherapy in hospitals" (18), Knight was joined by others over the next five years who would become major figures in American psychiatry and psychology: Roy Schafer, Ph.D., Allen Wheelis, M.D., David Rapaport, Ph.D., Margaret Brennan, Ph.D., Eric Erikson, and David Shapiro, Ph.D. (13).

Knight molded the Austen Riggs Center (ARC) around his philosophy that the "borderline schizophrenic patient... usually needs more organized support between treatment hours than living at home provides, but a closed hospital may, in attempting to provide complete support, actually accomplish the opposite" (19). Knight suggested "the answer to this dilemma would seem to lie in the therapeutic setting such as an open sanitarium ... where quantitative flexibility of support can be provided as needed, but where essentially the patient is encouraged and permitted to remain in charge of himself" (19). The point of such an environment was to assist the patient to move to a healthy sense of "self-esteem, a sense of responsibility for his behavior, and a feeling of maintaining inner controls over himself" (19). The mainstay of treatment was psychoanalytic psychotherapy modified to meet the needs of the

less than totally sound ego (19). Beyond individual therapy Knight required there to be group programs-therapeutic, social, and leisure (13).

Two years after Knight's death in 1965, Otto Will, trained by Harry Stack Sullivan and Freida Fromm-Richmann at Chestnut Lodge, became ARC's Medical Director (20). Will brought to ARC an extensive experience in the psychotherapy of the "schizophrenic reaction" (21). Will carried on what Knight had established, underscoring the need for an open setting (22), intensive psychotherapy (23), and a milieu that functioned synergistically with the psychotherapy (24). Will pointed out, as perhaps no one had before, the reasons there were (are) so few facilities such as ARC: 1) not many patients have sufficient funds for such treatment; 2) federal and private support is directed toward biological research with its promise of more rapid and dramatic results; 3) patients treated in these centers are often treatment failures elsewhere and do not respond rapidly to treatment; 4) staff require intensive, prolonged training which may discourage them from this form of work; 5) the expense of running such a center is high and is not easily met by patient fees; 6) many clinicians do not like to work with persons with borderline or psychotic diagnoses, and 7) centers of this nature seem to be seen as anachronistic (23).

In 1978, Daniel Schwartz became ARC's Medical Director. While he attempted to stay the course, ARC's treatment philosophy had to withstand the "revolution in biological psychiatry," the increase in demands for standardization by accrediting organizations, greater requirements for risk management in an ever increasing litigious society, and a fundamental challenge to the basic concepts of psychological illness. By the beginning of the 1990's, ARC was in a crisis (20).

In 1991 Edward Shapiro, a transplant from McLean Hospital, became ARC's latest Medical Director. When he arrived, ARC had a million dollars in accounts receivable, a \$6 million budget, and a small endowment (25). Shapiro began to reorganize ARC while recommitting the Center to its mission, referring to the unique setting and all its implications as a "community of examined living" (26). By 1993, the census had risen, the financial picture had improved. At that time President Clinton announced his plans for national health reform and within a month, admissions to East Coast psychiatric hospitals plummeted. ARC began to lose a hundred thousand dollars a month (25). In response, ARC reduced its staff by almost one-third, continued to develop symptom-focused groups, "placed more weight on the therapeutic community and on the patients' capacities to manage themselves," increased the linkage with families, and paid more attention to managing with limited resources (25). ARC began to move aggressively to market

itself under the banner "The Austen Riggs Center: Where Treatment-Resistant Patients Become People Taking Charge of Their Lives" (25). ARC developed contracts with managed care companies to treat their "treatment resistant outliers" (25). To provide outcome data, ARC began a long term study of treatment results "focusing on the differences between symptom change (which is rapid and temporary) and character change (achievable only with substantial treatment)" (25). ARC expanded its training and research activities, founding in 1994, upon the death of Erik Erikson, the Erik H. Erikson Institute for Education and Research. Among its other tasks, the Institute will examine ARC itself, posing such questions as: why do ARC's patients respond to an open setting after they have failed in locked settings? What are the salient issues of ARC's therapeutic community that establishes contexts for learning? (personal communication, Edward Shapiro, October 9, 2003).

At the turn of the millennium ARC was doing well. With a capacity of 60 patients across a three-tier system of care - an inpatient unit (with two levels within it), a halfway house and a day treatment center (27) - ARC had a progressively greater census from 1995 to 2000 (27) with a growing waiting list in 2002 (26). One interdisciplinary team follows a patient through all settings. ARC's contemporary patient population (20) is not very different in age, gender, education, socioeconomic status, or psychopathology from the population in Knight's era (13). Nor is its mission or treatment philosophy.

Despite *its* success, a center of ARC's size and uniqueness is never without threat or challenge. In the winter of 2002 ARC faced a lawsuit for malpractice (28). In some respects the entire concept of "examined living" appeared to be on trial. Day after day, headline after headline pounded away at ARC's handling of the patient (plaintiff: "Austen Riggs' employees violated nursing standards, witness testifies" (29); "Riggs erred in care of patient, witness claims" (30); "Austen Riggs team leaders claim ignorance of sexual relationship" (31); "Patient's parents: Riggs didn't take concerns seriously" (32); "Riggs patient tells of affair with nurse" (33). The jury returned a mixed verdict, holding some defendants at fault, exonerating others.

Throughout 2002, ARC operated at near 100% occupancy with a waiting list of 8 to 25 persons. The length of treatment increased (median 308 days) so the number of admissions - 42 and discharges - 43 decreased when 2002 is compared to 2001 or to any year 1998-2001. The mean annual census increased to 64.6 patients (58.8 in 2001). Diagnoses of patients continued to maintain a general consistency from previous years; in 2002, 69% of admissions had a primary diagnosis of

an Axis I mood disorder; 11% psychosis; 14% personality disorder. Including primary and secondary diagnoses, 80% of the patients fell into the category of "treatment refractory mood disorders." Patients funded their treatment as follows: 59% of patients paid for their entire treatment themselves; 24% used insurance plus private resources; and 17% used insurance alone. The number using insurance alone in 2002 was almost twice as high as the percentage was in 2001 (9%). This change in insurance reimbursement was seen by ARC as an indication that insurers might be recognizing the cost benefit of longer-term treatment for persons with treatment refractory disorders (34).

The trends noted in 2002 continued through 2004. Inquiries about admissions increased by 21% largely through the impact of ARC's website. The waiting list ranged from 5 to 18 patients with a mean of 13 persons. There were 124 admissions in 2004; two-thirds of them were women. *The* population served continued to be one difficult to treat with 87% having treatment refractory mood disorders, 40% having substance use disorders, 21% having eating disorders, 14% having PTSD, and 10% with a principal diagnosis of some form of a psychotic disorder. The median length of treatment in 2004 was 7.5 months (35).

While ARC successfully carries on a long tradition of a certain type of private psychiatric hospital, it may more and more be called upon to explain itself, in part because there are virtually none left like it. The uniqueness of ARC can well be appreciated by noting that it has a formal alumni association, made up of former patients and staff (34). While ARC's treatment regimen is anything but archaic - 98% of its patients are on psychoactive medication (Personal communication, Edward Shapiro, October 9, 2003) - it has the feel of a small town New England campus of an era gone by (personal observation). As recently described, ARC is "a determined tortoise in a world of eager hares. It has the feel of something that belonged to a different generation but has not outlived its usefulness, like an old and beloved desk" (36). But even a tortoise moves forward. And so too is ARC, During the period 2005 to 2006, ARC is constructing a Patient Community Center attached to its principal patient residence (35).

## CONCLUSION

As we consider the future of the private psychiatric hospital, we might look back upon some of the comments made by 19th Century leaders of American psychiatry in their evaluation of psychiatric hospitals and

treatment. There are lessons here for both clinicians and administrators of private facilities,

In terms of hospitals themselves, Isaac Ray indicated in 1852, "In the plan and details of construction, the single consideration of cheapness has been too much allowed to prevail over that of perfect adaptedness of purpose. The question that overrides every other is, not how the proposed object can best be accomplished, but how much will it cost" (37)? Thirty years later John Callender remarked, "An unsightly, forbidding, and improperly constructed hospital for the insane is something more than an exhibition of false economy: it is unscientific, inhumane, and unworthy of the utilization it is erected to symbolize" (38).

In terms of who needs hospital treatment and for how long, Thomas Kirkbride indicated in 1867, "My observation has not led me to have any fears of injury from patients remaining too long in this Institution, while the number I have known to suffer from being here too short a time has been very considerable" (39). On the other hand, at around the same time, Andrew McFarland opined, "To an insane person whose domestic attachments remain firm, and whose delusions in no way impair the moral affinity which should exist to those about him, removal to the society and care of strangers is a measure of, at best, questionable expediency\*" (40).

In terms of treatment, psychiatry seems willing to congratulate itself wherever it is along its course of evolving capabilities. In 1893 J.B. Andrews declared, "The medical treatment of the insane has been improved by the great strides made in materia medica and therapeutics — Remedies are now employed to meet the symptoms of disease in a more rational manner than ever before in the history of medicine" (41). Samuel Woodward, APA's first President, indicated 47 years before Andrews' remarks that "in this age of improvement, no class of mankind have felt its influence more favorably than the insane" (42).

If nothing else, in planning the future of inpatient psychiatry in America, we should be humble. Psychiatry has been struggling with cost-benefit equations, proper loci of treatment, and an evaluation of the value of what psychiatry has to offer in much the same manner for at least 200 years. Is the future of private inpatient psychiatry embodied in the broad-based, multifunction organization exemplified by Sheppard Pratt Health System? Is the future to be found in small, focused facilities that can offer extensive longer-term treatment to individuals who have been treatment refractory, such as the Austen Riggs Center, with all other treatment being delivered on an outpatient basis? Will the two models co-exist and even refer patients between them?

Will the distinction between private and public facilities disappear as national policies on health insurance for mental illness shift?

Whatever the future of the private psychiatric hospital, we put that future at risk, if we fail to learn from the history of the private psychiatric hospital what worked, when, and why.

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