Behavior therapy has made significant advances in the treatment of psychiatric patients since the mid-1960s. The opportunity to apply behavior therapy in psychiatric settings, however, depends on administrative factors within the settings. Because behavior therapy is a relative newcomer to hospital treatment, crosscuts usual professional boundaries, and contradicts aspects of the medical model, it does not readily “fit” in the psychiatric hospital structure. The collective experience of behavior therapists in psychiatric settings points to common organizational issues that may arise in the hospital practice of behavior therapy.

The Hospital Setting

General Issues

Behavior therapists in psychiatric hospital settings find themselves in the midst of physician-dominated institutions, organized around the medical model of illness and treatment. The traditional hospital is a large bureaucracy with a rigid hierarchy of professional disciplines. Although each profession provides specific services for patients, frequent collaboration is necessary, and roles may overlap. Unlike the established medical professions, behavior therapy is typically outside the hospital power structure and lacks a specified place in the organization. As noted by Hersen (1979), there are enormous possibilities for conflict, dissent, and chaos in the psychiatric setting for behavior therapists.

Another prominent feature of hospital operations is a concern about costs. The hospital is a big business and is driven, at least in part, by economic considerations. Although the particular financial incentives vary by the type of hospital and the source of money, hospital efforts to increase revenues and reduce expenses are now universal. Even apart from issues of direct

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FAITH B. DICKERSON • The Sheppard and Enoch Pratt Hospital, 6501 North Charles Street, Baltimore, Maryland 21204.
patient care, behavior therapists may be influenced by economic contingencies operative within the hospital setting.

Behavior therapists in hospital settings not only are confronted by a complex, economically driven medical system but also espouse a model of treatment that is at odds with the psychiatric establishment. Psychiatry is currently dominated by biological and psychoanalytic models, with behavior therapy lying outside the psychiatric mainstream. Psychoanalysis is declining from its former dominance but still exerts some influence in most psychiatric settings and is usually part of the training of psychiatric residents. The biological model has overtaken psychoanalysis as psychiatry has become "remedicalized." In most psychiatric settings, there is now an increasing emphasis on the organic basis of psychiatric illnesses and treatment.

Behavior therapy challenges both the psychoanalytic and the biological ideologies, but it is more compatible with the biological model. The emergence of the biological model has permitted more collaboration with behavior therapy in psychiatric settings. Both the behavioral and the biological approaches are symptom- or problem-focused and take an objective, empirical stance toward treatment. Competition between the models still occurs. Conflict may emerge around the issue of which treatment to try first or around what caused clinical change ("It was the meds that made the patient better"); "No, the patient's improvement was due to the behavior program"). However, the models can complement and enrich each other and lead to an integrated treatment approach.

Types of Hospital Settings

Psychiatric hospital settings can be divided into those that are publicly funded and those that are in the private sector, either proprietary or not-for-profit. Psychiatric units within university hospitals constitute another group; they may combine features of both public and private settings and also provide training and research.

The public sector is composed primarily of state and veterans' (VA) hospitals. These settings tend to accumulate a population of chronically ill, geriatric, and indigent patients who have exhausted private health insurance benefits. The hospital settings themselves may lack professional and financial resources, a lack adding to the challenge for mental health professionals. For these reasons, there have been fewer competing models of care in public settings. Psychologists and behavior therapists have assumed broad roles in developing and carrying out treatment in these public facilities. In fact, it was in state hospitals that the early and pioneering behavioral work with psychiatric patients occurred (Ayllon & Azrin, 1968; Schaefer & Martin, 1966).

The current status of behavior therapy in public hospitals is highly variable. Given the relatively fewer numbers of professional staff in public than in private settings, psychologists and behavior therapists may have wide professional latitude and a wide range of responsibilities, enabling them to implement behavior therapy programs. On the other hand, public systems may be handicapped by limits in the funding and administrative support that are necessary for program development. Additionally, public hospital staff may be accustomed to providing custodial care and may resist the demands of active treatment such as behavior therapy. If public hospitals have a university affiliation, as many VA hospitals do, they are likely to have access to academic departments of psychology and trained behavior therapists, as well as greater overall professional resources.

Behavior therapy is underused in public, as well as in private, settings, despite its proven efficacy with severely disturbed psychiatric patients. A survey of VA hospitals in the mid-1980s (Boudewyns, Fry, & Nightingale, 1986) revealed that only 6.6% of all VA psychological services had social learning programs, and that only about 1% of all psychiatric patients in the VA system had access to this form of treatment. Survey respondents cited resistance to behavior therapy by their hospital administrations, as well as misconceptions of behavior therapy by nursing staff.