Hun Millard¹,* , Susan Parke¹, Cynthia Wilson¹, Zheala Qayyum¹, Hyun Jung Kim² and Timothy Van Deusen¹

¹Yale University School of Medicine, Psychiatry, New Haven, CT, USA; ²Harvard Medical School, Psychiatry, Boston, MA, USA

Article History:
Received: March 09, 2019
Revised: May 08, 2019
Accepted: May 22, 2019
DOI: 10.2174/2210676609666190617150025

Abstract: Background and Goals: The role of milieu therapy on inpatient treatment has become more prominent due to the changing landscape of hospital care, with shorter length of stay, higher patient acuity, and rapid turnover. The modern inpatient unit promotes less individual psychotherapy with the psychiatrist or therapist, and more milieu and group based treatment that emphasizes acute stabilization.

Methods: The authors share some of the core domains that provide the basic framework for milieu treatment within an acute care setting when working with adolescents and transitional age youth (TAY), with the aim to share clinical considerations for milieu therapy and offer practical ideas for implementation in clinical practice.

Discussion: The therapeutic milieu and collaboration of an interdisciplinary team has a significant impact on hospital treatment. Considerations for milieu therapy implementation in an inpatient unit include developmentally informed concepts related to milieu treatment of adolescents and TAY patients in a hospital setting.

Keywords: Child and adolescent psychiatry, adolescence, transitional age youth, inpatient, milieu treatment.

1. INTRODUCTION

In the acute inpatient psychiatric setting, the milieu plays a significant role in treatment. Milieu is a French word which translates to environment. Therapeutic milieu refers to the setting and cohort of people in which treatment occurs with the goal of promoting wellness and healing. Milieu therapy is a psychiatric behavioral approach that emphasizes multidisciplinary collaboration, patient involvement, open communication, collective responsibility, and views the structured environment as treatment in and of itself (Gutheil, 1985; LeCuyer, 1992; Saifnia, 1984). While we now use the phrase therapeutic milieu, therapeutic community, milieu therapy, and milieu treatment interchangeably, there is a historical context in which these terms developed. Theoretically, “moral treatment” could be considered the beginnings of early milieu therapy; Dr. Philippe Pinel, in the late eighteenth century, called for more compassionate care of non-violent individuals with mental illness in a Paris asylum where patients were allowed to move about freely (Gutheil, 1985; Saifnia, 1984).

In the 1950’s, Maxwell Jones developed a “therapeutic community” model of treatment, moving away from a physician-patient model to a more inclusive, interdisciplinary approach in which staff and patients jointly established goals of daily living, socialization, and treatment aims (Ellsworth, 1971). The idea was that patients would develop greater insight into their behavior through feedback from multiple treaters. Bruno Bettelheim, who worked with children in residen-
tial facilities, created the term “milieu therapy” and “therapeutic milieu” to emphasize thoughtful manipulation of the total environment as treatment to improve social and emotional skills (Saifnia, 1984). He believed there was tremendous opportunity to shape behavior by skillfully manipulating everyday living routines, schedules, and structure, and that all staff interactions could contribute to this process (Noshpitz, 1992).

Milieu therapy was originally developed in long-term settings, which were dramatically different from today’s modern hospital acute care setting. Current acute care psychiatric hospitalizations are characterized by shorter lengths of stay, greater influences from insurance companies (Robinson & Avallone, 1990), and less individual time with therapists and psychiatrists who are under administrative pressure to acutely stabilize, refer, and discharge patients (Kleespies, 1986). Furthermore, there has been a paradigm shift from physician dominated leadership to a broader team and patient based approach with input into the daily schedule, structure, and treatment goals (Saifnia, 1984). This certainly makes sense given that nurses and ancillary staff often observe and interact with patients more frequently than physicians do. Many patients develop strong attachments to the staff with whom they spend the majority of their time, and these relationships often become more important than those with their individual therapist and doctors (Leon Hoffman, 1982).

An inpatient unit further provides a setting where social aspects of treatment can be practiced, by encouraging socialization with peers through group therapy and staff monitored activities. The therapeutic milieu can be shaped to provide a holding environment for patients as well as prevent regression while patients are hospitalized (Silvan, Matzner, & Silva, 1999). Milieu treatment can add value to all patients and provide support to individuals who have experienced significant abandonment or rejection. These experiences over time can result in intolerable, intense individual relationships, which can be alleviated with milieu support and interpersonal connections with various staff members (Hoffman, 1982). Furthermore, milieu therapy promotes opportunities to have a voice, share experiences, and contribute to the treatment process while strengthening the individual’s sense of competence and self-agency.

In this paper, we share some of the core domains that provide the basic framework for milieu treatment within an acute care setting when working with adolescents and transitional age youth (TAY). While certainly not an exhaustive discussion, the aims of this paper are to share clinical considerations for milieu therapy and to offer practical ideas for implementation in clinical practice.

2. STRUCTURE

A consistent daily schedule offers a structure for expectations and behavior as well as a frame for patients within which to feel safe. In an acute setting, daily morning “check-ins” during the “community meeting” is typically done with patients sharing news and verbalizing their treatment goals for the day. The community meeting is different than group therapy in that it is a time in which all patients gather collectively and it is typically more structured than psychotherapy (Hoffman & Wagner, 1982). It is a forum to share news (e.g., discharges, goals, patients’ assigned nurse for the shift, etc.), make announcements (e.g., special events or activities), and review the daily schedule. One should consider the arrangement of the physical space such as the positioning of chairs in the common areas to promote dialogue and socialization. For instance, community meetings are typically arranged so that patients are seated in a circle, fostering eye contact and allowing greater visibility of one another.

The open expression of individual news and goals at the start of the day can allow patients to experience accountability from others, and aims to cultivate cohesiveness among staff and patients. The idea of increased patient responsibility is a core concept of therapeutic community models of care (Ellsworth, 1971), and patients take an active role in sharing and co-facilitating. For example, a volunteer may make general announcements, another may review rules/expectations of the unit, and one more may serve as a scribe to write participants’ individual goals on a whiteboard. Community meetings throughout the day can offer additional group check-ins. For instance, an afternoon community meeting helps orient patients to second shift change of staff and offers introductions to newly admitted patients who are joining the milieu.
Scheduled activities, meals, and sleep time not only add to the predictability and structure of the day, but also promote healthy biologic rhythms. Sleep is an essential part of physical and emotional health, and insufficient sleep has implications for academic performance, interpersonal relationships, and emotional and behavioral regulation (Table 1). Some studies suggest that sleep problems are associated with suicidal ideation and attempts, and proceed the development of anxiety and depression in adolescents (Kaplan, Ali, Simpson, Britt, & McCall, 2014). Beyond the scheduling of sleep and bed times, the inpatient environment can control variables such as light, screen time, temperature, and to some extent, sound and emotionally charged stimulation (e.g. calming activities and limited phone/family visits close to bedtime). Structure naturally promotes good sleep hygiene and the staff/treatment goals can further emphasize this by incorporating psychoeducation about sleep hygiene into group or individual sessions. Additionally, periods of free and quiet-time intervals offer reprieve and balance to therapeutic groups and meetings with clinicians which can be emotionally challenging to patients.

The predictability that unit structure creates is not meant to be authoritative or restricting to the individual. It provides a consistent and safe place for interpersonal engagement and development of personal growth. Often the acute crises that lead to an inpatient admission and the everyday community experience of patients admitted to inpatient psychiatric units can be chaotic and dysregulating. The milieu structure fosters a setting in which ego strength, self-control, emotional and behavioral

Table 1. Sample daily schedule.

| Time       | Activity                                      |
|------------|-----------------------------------------------|
| 7:30AM     | Wake Time and Hygiene                         |
| 8:00AM     | Breakfast                                     |
| 9:00AM     | Community Meeting (entire unit participates)  |
|            | Rounds/Check-in*                              |
| 10:00AM    | Group Therapy (45 Minutes) or School (for adolescents) |
|            | Most scheduled Group Therapy times have two or more options, broken down typically by cognitive and social-emotional level and consideration of patients’ individual treatment goals and safety (if group is off the unit) |
| 10:45AM    | Break/Snack                                   |
| 11:00AM    | Group Therapy (45 minutes)                    |
| 11:45AM    | Recreation/Outdoor Activities Group (for young adolescent unit) |
| 12:00PM    | Lunch                                         |
|            | Quiet Time                                    |
| 1:15PM     | Group Therapy (45 minutes) or School          |
| 2:10PM     | Group Therapy (45 minutes)                    |
| 2:50PM     | Snack                                         |
| 3:00PM     | Sensory Modulation and Relaxation Group, Progressive Muscle Relaxation, Yoga, Mindfulness, Guided Imagery, Five Senses |
| 4:00PM     | Recreation/Outdoor Activities Group           |
| 5:00PM     | Quiet Time                                    |
| 6:00PM     | Dinner                                        |
| 7:00PM     | Alcoholics Anonymous (AA) Meeting             |
| 8:00PM     | Community Movie                               |
| 10:00PM    | Bed Time                                      |

*Patients meet with their individual Psychiatrist and Social Worker daily, as time permits, and individually with the Occupational Therapist as indicated.
regulation, and prosocial behaviors can be developed and practiced (Silvan et al., 1999). For youth in particular, the containment created by the knowledge that the staff/units are predictable allows the teen to know that they are not omnipotent. Others are in charge and keeping everyone safe and thus they may begin the work of tolerating their thoughts and feelings in a supportive and consistent environment (Gunderson, 1978).

3. SOCIALIZATION

Patients often experience feelings of isolation owing to the symptoms and suffering related to their mental illness. Peers who have experienced similar struggles can offer a great deal of support to one another. The spontaneous peer relationships that develop in the milieu add a valuable scaffold for patients, especially in the context of a contained environment where milieu staff are constantly present to monitor and maintain appropriate boundaries. When conflicts arise amongst peers, staff is available to process and manage these interpersonal crises in a controlled setting thus providing patient’s opportunities to build skills such as interpersonal effectiveness.

Many psychiatric disorders affect patients’ social skills and competence. Social competence can mean the ability to garner real personal goals through interacting with others in various situations (e.g. home, school, work, and community). Social skills/competence can be defined as appropriate behaviors that when used sequentially with others lead to success interpersonally and in daily living. Social skills training uses behavioral therapy principles and techniques to teach patients to communicate their emotions and requests in order to meet their needs which is a skill required for independent living. For example, teaching “I” statements with role playing helps individuals practice self/other reflection. Other important skills relate to the management and stabilization of one’s mental disorder and the appropriate expression of empathy, affection, sadness, and other emotions when dealing with others. Moreover, social skills training can offer protective effects such as contributing to the stabilization of individuals’ illnesses, improving adherence to medication and psychosocial treatment, and promoting recovery.

When psychiatric disorders are diagnosed in early childhood (e.g. autism, attention deficit hyperactivity disorder, learning disabilities), children’s ability to develop social competence can be affected leading to social skill deficits. Given the complex nature of social relationships, social skill deficits are pervasive among individuals with neurocognitive and learning disabilities. It has been estimated that between 20 to 35% of individuals with neurocognitive disabilities display some type of maladaptive behavior such as self-injury and aggression, which may be detrimental to the development and display of appropriate social skills (Duncan, Matson, Bamburg, Cherry, & Buckley, 1999). However, it is unclear if social skill deficits result in maladaptive behaviors, or if the presence of maladaptive behaviors results in social skill inadequacies. In either case, identifying and targeting specific social skills problems for treatment is important, including basic self-care domains impacting the patient’s socialization. For example, a common issue for the milieu is the adolescent patient with poor hygiene. Often milieu counselors can tactfully discuss the presence of body odor or their inattention to hygiene and provide education about proper hygiene techniques. This can be done in a manner that, although challenging, can be both educational and validating for the patient and help improve their social interactions.

An essential developmental task of adolescence includes the ability to form friendships with peers. Studies indicate that early social impairment tends to promote later impairment because the individual arrives at each progressive stage of development with inadequate resources available to meet the challenges unique to the ensuing developmental period (Goldstein, Miklowitz, & Mullen, 2006). Youngsters with impoverished social skills tend to gravitate to social environments not conducive to improving these deficits. In addition, parental overprotectiveness and social withdrawal from peers can accentuate their low social competence. Thus, impairment in social skills evident in childhood and adolescence frequently continues throughout adulthood and manifests itself in difficulties with adult interpersonal relationships. Social skills training through a variety of outlets, both facilitated and in vivo, lends itself well to implementation during inpatient hospitalization. Education can be provided for basic social etiquette, such as appropriate eye contact during conversation, shaking hands upon meeting, and smiling when greeting others. Further, feedback about important nonverbal cues such as speech
intonation and volume, body posture and gestures, and physical boundaries can be discussed, modeled, and role played. More advanced social skills such as expressing one’s opinions, perceiving others’ thoughts/feelings, and practicing appropriate emotional responses can be taught and learned through facilitated groups and activities. In this way, the inpatient milieu can be used to improve individuals’ capacities for interpersonal effectiveness, thereby improving post discharge social skills.

The inpatient milieu offers valuable opportunities for appropriate socialization feedback. Often mental health professionals have traditionally been taught not to give direct guidance. We would assert that at times direct guidance is helpful, especially for younger patients in crisis. While being mindful to support and encourage prosocial behaviors, we also want to provide honest feedback about areas in which patients may have mishandled a situation and use these opportunities for constructive teaching and skill building. For example, adolescents often seek direct feedback in dealing with difficult peer interactions. Given that milieu staff often witness these interactions directly, they are in a unique position to provide such guidance which youth can then apply to future social interactions upon discharge. Youth often solicit advice about their interactions in groups with peers, as well as about their adult interactions, including their parents. Older youth may have different feedback needs, such as a desire to discuss romantic choices. There are many times when youth may not request staff feedback or guidance, but staff may feel that offering it during a pivotal moment may be beneficial.

4. GROUP THERAPY

Group therapy is an important component of milieu treatment. In a hospital setting where stays are brief, patient acuity high, and needs diverse, group therapy can serve an important role in unit stability. These groups improve interpersonal skills, behavioral outcomes, and reduce symptoms (Emond & Rasmussen, 2012). This mode of therapy is the most frequent treatment modality within hospital settings (Sugar, 1993) and can improve individuals’ peer/staff connection and therapeutic alliances. Furthermore, group therapy lessens feelings of isolation and stigma, and can significantly reduce the initial anxiety of being a new patient on a psychiatric unit (Emond & Rasmussen, 2012). Patients meet one another in a controlled setting, facilitated by a group leader, and have a shared experience within a unique, unfolding group process. For some patients who might otherwise have avoided this treatment modality, exposure to inpatient group therapy offers an opportunity to experience its potential benefits. For example, as exposure to unique peer based support and the therapeutic benefits of talking about oneself as well as hearing about other’s experiences. In addition, for a variety of reasons such as school or work conflicts, inpatient groups may be the only time an individual has such an opportunity.

Experienced clinicians facilitate the group process to promote self-awareness and improve interpersonal skills (Bernstein & Duquette, 1995). Group therapy is a forum to build cohesion, support one another, learn new behaviors, and then practice them in the milieu (Silvan et al., 1999). For example, early in the day, a patient may learn through an anger management group to “stop and think,” “take a break,” wait until he/she is calm, and to use “I statements” in conflict resolution. Later, when a disagreement with a peer occurs, instead of immediately reacting, he/she may try these new behaviors and skills. Naturally, groups can foster peer relationships, promote involvement, and a sense of belonging and acceptance (Bernstein & Duquette, 1995). Facilitating social interactions and offering opportunities for skill building and self-reflection within a supportive group environment can decrease loneliness and psychiatric symptoms.

During adolescence and young adulthood, there is an opportunity to leverage a strong therapeutic alliance to treatment through peer based groups. Developmentally, this is a period in which individuals seek peers for identity formation and validation. Peer opinions can often be received with less resistance than those from adults. For instance, an individual who is highly disruptive during group may become more disruptive or oppositional when staff calls attention to their behavior. Alternatively, a supportive group of peers able to provide the identical feedback may have more potential to create the space necessary for reflection and increase motivation to change a behavior.

On the unit, a structured schedule is provided with a variety of group themes and topics that
change daily, and patients are often given two choices so that they may feel empowered to express their preferences when choosing a particular group. Having options also allows for unique treatment considerations. While many aspects of milieu treatment emphasize structure, the overall goal of providing individualized treatment plans based on different diagnoses and developmental needs remains fundamental (Robson, 1994). For example, there are often groups geared toward individuals with lower cognitive abilities, who are disorganized due to psychosis or other mental illness, or who have particular socioemotional issues they may want to address. Higher functioning participants may experience boredom in less challenging or more concrete groups. Flexibility in group programing is important and some may be more fluid and nondirective, while others are more focused and instructive.

Group therapies are often informed by evidence based practices, such as dialectical behavior therapy (DBT) or cognitive behavioral therapy (CBT). These models, based on the literature, suggests positive clinical benefits within brief periods of time. While helpful manualized approaches exist, the experience of individual providers remains an important consideration. Group leaders should have some expertise leading groups with several treatment modalities, and in order to allow the group process to unfold, they should not dominate the conversation. They also need to be aware of their own anxiety around uncomfortable feelings that may arise in the group.

Given shorter hospitalizations and often less individual time with clinicians, in addition to setting goals and moving toward discharge, group therapies serve an important role in fostering symptom reduction. Many groups incorporate coping skills and healthy ways of managing stress and anger and of decreasing depression and/or behavioral symptoms. The following table is a list of the variety of groups utilized in an adolescent and TAY inpatient service (Table 2).

### 5. OCCUPATIONAL THERAPY

Occupational therapy focuses on the functional health of patients, emphasizing the individual’s

| Process Oriented Groups | Recreation and Activities |
|-------------------------|----------------------------|
| • Anger Management      | • Art / Craft Therapy      |
| • CBT Groups (Coping with Anxiety, Coping with Depression) | • Board Games |
| • Coping Skills Acquisition Group | • Icebreaker |
| • DBT Groups (Radical Acceptance, Mindfulness, Distress tolerance, Emotion Regulation, Interpersonal Effectiveness) | • Indoor Recreation (Ping Pong, Video Gaming) |
| • Socialization Therapy | • Mindfulness |
| • Speaking your Truth (LGBTQ) | • Music Therapy |
| • Types of Communication (Problem Solving, Passive Communication, Assertive Communication) | • Outdoor Recreation |
| • Trust Building | • Pet Therapy |

| ADLs/iADLs Based Groups | Other Groups/Activities |
|-------------------------|-------------------------|
| • Budgeting / Managing Money | • Alcoholics Anonymous (AA) |
| • Cooking / Meal Preparation | • Discussion Group with Chaplain |
| • Cope Ahead/Weekend Planning | • Hearing Voices |
| • Functional Skills Building | • Medication Education (with PharmD) |
| • Health & Wellness (Nutrition / Diet, Brain Fitness) | • Parent / Caregiver Support Group |
| • Jumpstart to Wellness (Goal Setting) | • School / Study Time |
| • Seeking Safety | • Substance Abuse / Co-occurring Disorders |
| • Self-Care | • |
| • Sleep Hygiene | • |
competence and ability to be successful in activities of daily living, while considering personal goals within appropriate social and cultural contexts (Robinson & Avallone, 1990). Inpatient occupational therapists begin by performing an assessment of individuals’ strengths, lifestyle, abilities (cognitive, motor, social, functional), and roles and routines in the community, and identifying areas that could benefit from change. Further, occupational therapists assist in creating a structure and plan for opportunities to integrate meaningful activities into the various aspects of daily hospital living. This treatment plan should parallel roles and be representative of out of the hospital activities, for example, performing daily hygiene, weekly laundry, calling one’s school advisors, scheduling homework time, etc. Goals are formulated while understanding the limitations of what may be accomplished during an acute care setting, given the acute exacerbation in mental health symptoms, the length of stay, and the artificial environment of a hospital setting (Robinson & Avallone, 1990). For example, patients are provided a daily schedule hand-out which serves to foster time management while mimicking an individual’s schedule of appointments/calendar in the real world. An initial individual meeting between the occupational therapist and newly admitted patient serves not only as an important preliminary functional assessment, but also as a point of entry to prepare patients for participation in programming and thus orient and improve therapeutic benefit (Polimeni-Walker, Wilson, & Jewers, 1992).

Occupational therapists actively engage in interdisciplinary team treatment planning and create programming which fit within the existing unit structure and incorporate both individual and group activities. For example, a young adult preparing to transition from living with a foster family to a semi-independent group home will participate in groups about self-care, sleep hygiene, and community resources, as well as meet individually with the occupational therapist to learn about budget planning and practice cooking and laundry skills. Alternatively, the individual aspiring to attend college may need individual support with regard to what information he/she will need to gather, such as where to locate/access admission applications and financial aid information.

Occupational therapy can serve a particularly important role in milieu treatment for the TAY population by evaluating patients and their needs in terms of adapting and optimizing functioning in home, work, and school environments during a significant time of developmental growth and change. For TAY, this is a particularly important treatment modality as they attempt to navigate new experiences as young adults. Skills needed for independent living are introduced in a variety of domains including education about community resources, healthcare management, finances, medications, and safety which are all important skills to learn at this developmental stage. Basic training in activities of daily living, such as self-care and hygiene, as previously discussed, are also important to cover. Patients are often unsure but eager to gain greater independence and engage in learning about housing, school, and job training resources. Occupational therapists serve a valuable role as members of the inpatient team, performing functional assessments, identifying goals, and making treatment recommendations to promote engagement in daily activities. Moreover, these therapists are able to identify supports and services that a patient may need upon discharge to improve his/her daily living (Robinson & Avallone, 1990).

6. RECREATIONAL AND OTHER ACTIVITIES

According to the American Therapeutic Recreation Association, recreational therapy provides treatment services to persons with illnesses or disabling conditions in order to restore, remEDIATE or rehabilitate, improve functioning and independence, health and wellbeing, and reduce or eliminate the effects of illness or disability (Polimeni-Walker et al., 1992). The variety of recreational activities across hospitals can vary greatly, all offering opportunities for relaxation, learning, and socialization.

Being confined within a locked hospital unit can be taxing. Some hospitals possess the staff and structure to allow for outdoor exercise and, while rarer, community outings. Within the hospital, patients often benefit from, and enjoy, the ability to express themselves creatively through arts, crafts, and music. For example, because patient challenges in interpersonal and intrapersonal skills can lead to decreased motivation for the more verbal
therapies, music therapy can improve relational abilities (Mossler, Chen, Heldal, & Gold, 2011) and has particular appeal to an adolescent/TAY population. Adolescents specifically can benefit from less structured activity based groups, promoting greater engagement, and offering reprieve from process oriented groups which can be overwhelming. Playfulness and physicality are important therapeutic domains.

Animal-assisted therapy has been shown to have significant therapeutic impact on hospitalized patients as well. The biopsychosocial benefits show that positive interactions with dogs have been found to decrease cortisol, epinephrine, and norepinephrine levels. They also include the increase in endorphin and oxytocin levels which are associated with social bonding/attachment, pleasurable sensations, and decreased pain and stress (Mossler et al., 2011). Anecdotally, even the most withdrawn patients have brightened, and often participated, when an animal arrives on the unit, offering a port of entry for greater therapeutic engagement.

Greater evidence and consideration are now being made to the sensory contributions to patient well-being. Many inpatient units now have “sensory rooms,” which aim to provide safe and comfortable spaces in which patients’ distress and agitation can diminish, thereby reducing crises, and potentially avoiding or reducing seclusion and restraint (Odendaal & Meintjes, 2003). The specially designed rooms provide stimulation via the different senses (sight, smell, hearing, touch and taste) in a purposively demand-free environment that is patient-controlled (BJorkdahl, Perseius, Samuelsson, & Lindberg, 2016). Appropriately used sensory rooms, in addition to providing alternative opportunities for de-escalation, can be supportive to patients, promote self-soothing and self-organization, and increase patients’ perceived level of choice and empowerment and ultimately contribute to skill development (BJorkdahl et al., 2016; Champagne & Stromberg, 2004).

CONCLUSION

The role of milieu therapy in acute inpatient treatment has become more prominent due to the changing landscape of hospital care, with shorter lengths of stay, higher patient acuity and turn over, insurance and fiscal tensions, and pressures for evidence based practices proven to be more concretely measurable in the context of brief admissions (Emond & Rasmussen, 2012). The ultimate goal of an inpatient milieu is to foster an atmosphere of healing and promote physical and psychological health. And, in addition to the physical environment and structure, the interdisciplinary team of providers (mental health counselors, techs, nurses, social workers, occupational therapists, psychiatrists and psychologists) collectively, in collaboration with patients, create the dynamic therapeutic milieu. The therapeutic milieu creates a setting of support in which patients have the availability of staff 24-hours a day. As challenges arise, overwhelmed patients have the immediate availability to seek out staff, feel nurtured, and validated. Appropriately dosed support is in the art of balance; too little and the patient can feel invalidated, too much and regression may be enabled or caused. Developmentally, it is especially important for this age group to gain more independence and have experiences of feeling competent to manage crises.

Adolescents and TAY face critical developmental tasks that need to be taken into consideration when developing milieu therapy. While separation and individuation processes take place throughout life, adolescence and emerging adulthood are critical periods when one’s sense of self becomes solidified. Thus, a strength based approach, fostering prosocial behaviors, identifying strengths, and promoting resiliency within the therapeutic milieu is of enormous importance. This can be done, in part, through thoughtful manipulation of the structure, groups, and activities of the inpatient milieu therapy within a developmentally informed culture. This philosophy should cultivate first rate communication and collaboration within the interdisciplinary team, and in partnership with patients, to provide validation and promote self-agency and greater autonomy.

ABOUT THE AUTHORS

Hun Millard, MD is Assistant Professor of Psychiatry at Yale University School of Medicine, Assistant Professor, Child Study Center, Yale University School of Medicine, and Attending Psychiatrist, Transitional Age Youth Inpatient Service, Yale New Haven Hospital, New Haven, CT.
Susan Parke, MD is Assistant Professor of Psychiatry at Yale University School of Medicine, and Medical Director at Community Forensics Services at Connecticut Mental Health Center, New Haven, CT.

Cynthia Wilson, MD is Assistant Clinical Professor of Psychiatry at Yale University School of Medicine, and Unit Chief, Adolescent Inpatient Unit, Yale New Haven Hospital, New Haven, CT.

Zheala Qayyum, MD is Assistant Clinical Professor of Psychiatry at Yale University School of Medicine, and a candidate for the Masters of Medical Sciences in Medical Education at Harvard Medical School.

Hyun Jung Kim, MD is Instructor in Psychiatry at Harvard Medical School, and Psychiatrist in Charge, Psychotic Disorders Division, McLean Hospital, Belmont, MA.

Timothy Van Deusen, MD is Assistant Professor of Psychiatry at Yale University School of Medicine, Assistant Professor, Child Study Center, Yale University School of Medicine, Attending Psychiatrist, Young Adult Services, Residency Site Training Director at Connecticut Mental Health Center, and Medical Director, West Haven Mental Health Clinic, West Haven, CT.

CONFLICT OF INTEREST

The authors declare no conflict of interest, financial or otherwise.

ACKNOWLEDGEMENTS

Declared none.

REFERENCES

Bernstein, E., Duquette, J.S. (1995). Inpatient group psychotherapy program: A model. J. Child Adolesc. Group Ther., 5(1), 35-45. http://dx.doi.org/10.1007/BF02550064

Björkdahl, A., Perseus, K.I., Samuelsson, M., Lindberg, M.H. (2016). Sensory rooms in psychiatric inpatient care: Staff experiences. Int. J. Ment. Health Nurs., 25(5), 472-479. http://dx.doi.org/10.1111/inm.12205 PMID: 26875931

Champagne, T., Stromberg, N. (2004). Sensory approaches in inpatient psychiatric settings: innovative alternatives to seclusion & restraint. J. Psychosoc. Nurs. Ment. Health Serv., 42(9), 34-44.

http://dx.doi.org/10.3928/02793695-20040901-06 PMID: 15493494

Duncan, D., Matson, J.L., Bamburg, J.W., Cherry, K.E., Buckley, T. (1999). The relationship of self-injurious behavior and aggression to social skills in persons with severe and profound learning disability. Res. Dev. Disabil., 20(6), 441-448. http://dx.doi.org/10.1016/S0891-4222(99)00024-4 PMID: 10641253

Ellsworth, R., Maroney, R., Klett, W., Gordon, H., Gunn, R. (1971). Milieu characteristics of successful psychiatric treatment programs. Am. J. Orthopsychiatry, 41(3), 427-441. http://dx.doi.org/10.1111/j.1939-0025.1971.tb01129.x PMID: 5549914

Emond, S., Rasmussen, B. (2012). The status of psychiatric inpatient group therapy: Past, present, and future. Soc. Work Groups, 35(1), 68-91. http://dx.doi.org/10.1080/01609513.2011.553711

Goldstein, T.R., Miklowitz, D.J., Mullen, K.L. (2006). Social skills knowledge and performance among adolescents with bipolar disorder. Bipolar Disord., 8(4), 350-361. http://dx.doi.org/10.1111/j.1399-5618.2006.00321.x PMID: 16879136

Gunderson, J.G. (1978). Defining the therapeutic processes in psychiatric milieus. Psychiatry, 41(4), 327-335. http://dx.doi.org/10.1080/00332747.1978.11023992 PMID: 715093

Gutheil, T.G. (1985). The therapeutic milieu: changing themes and theories. Hosp. Community Psychiatry, 36(12), 1279-1285. http://dx.doi.org/10.1176/ps.36.12.1279 PMID: 4086001

Hoffman, L. (1982). Philosophy of the milieu. The Evaluation and Care of Severely Disturbed Children and Their Families. (pp. 9-15). Dordrecht: Springer. http://dx.doi.org/10.1007/978-94-011-6299-9_2

Hoffman, L., Wagner, M.A. (1982). The Community Meeting - A Paradigm of Milieu Therapy. The Evaluation and Care of Severely Disturbed Children and Their Families. (pp. 101-106). Dordrecht: Springer. http://dx.doi.org/10.1007/978-94-011-6299-9_16

Kaplan, S.G., Ali, S.K., Simpson, B., Britt, V., McCall, W.V. (2014). Associations between sleep disturbance and suicidal ideation in adolescents admitted to an inpatient psychiatric unit. Int. J. Adolesc. Med. Health, 26(3), 411-416. http://dx.doi.org/10.1515/ijamh-2013-0318 PMID: 24356389

Kleespies, P.M. (1986). Hospital milieu treatment and optimal length of stay. Hosp. Community Psychiatry, 37(5), 509-510. http://dx.doi.org/10.1176/ps.37.5.509 PMID: 3699721

LeCuyer, E.A. (1992). Milieu therapy for short stay units: a transformed practice theory. Arch. Psychiatr. Nurs., 6(2), 108-116. http://dx.doi.org/10.1016/0883-9417(92)90006-5 PMID: 1596109

Mossler, K., Chen, X.J., Heldal, T.O., Gold, C. (2011). Music therapy for people with schizophrenia and schizo-
phrenia-like disorders. Cochrane Database of Systematic Reviews (12), 1-36. doi. ARTN, CD004025. http://dx.doi.org/10.1002/14651858.CD004025.pub3. PMID: 22161383.

Noshpitz, J.D. (1992). History of milieu in the residential treatment of children and youth. Educating the Emotions. (pp. 91-120). Boston: Springer. http://dx.doi.org/10.1007/978-1-4615-3316-0_4.

Odendaal, J.S.J., Meintjes, R.A. (2003). Neurophysiological correlates of affiliative behaviour between humans and dogs. Vet. J., 165(3), 296-301. http://dx.doi.org/10.1016/S1090-0233(02)00237-X. PMID: 12672376.

Polimeni-Walker, I., Wilson, K.G., Jewers, R. (1992). Reasons for participating in occupational therapy groups: perceptions of adult psychiatric inpatients and occupational therapists. Can. J. Occup. Ther., 59(5), 240-247. http://dx.doi.org/10.1177/000841749205900505. PMID: 10122890.

Robinson, A.M., Avallone, J. (1990). Occupational therapy in acute inpatient psychiatry: an activities health approach. Am. J. Occup. Ther., 44(9), 809-814. http://dx.doi.org/10.5014/ajot.44.9.809. PMID: 2221000.

Robson, K.S. (1994). Manual of clinical child and adolescent psychiatry. (Rev. ed.). Arlington, VA: American Psychiatric Association.

Saifnia, J.A. (1984). Milieu therapy. Mental health psychiatric nursing: A holistic life-cycle approach.. Toronto: The C. V. Mosby Company.

Silvan, M., Matzner, F.J., Silva, R.R. (1999). A model for adolescent day treatment. Bull. Menninger Clin., 63(4), 459-480. PMID: 10589139.

Sugar, M. (1993). Research in child and adolescent group psychotherapy. J. Child Adolesc. Group Ther., 3(4), 207-226. http://dx.doi.org/10.1007/BF00995396.