Milieu Therapy for Short Stay Units:
A Transformed Practice Theory

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Milieu therapy is an interdisciplinary treatment approach widely applied in psychiatric settings. Current short stay inpatient trends indicate a need to adapt the approach so that it remains useful for nursing practice in those settings. This report presents basic historical milieu concepts with their relationships to patient outcome; current short stay patient needs, outcomes, and nursing actions are developed and linked with the historical concepts. The resulting transformed theory can be seen as an adaptation of the classic approach, tailored to short stay settings, with short-term goals and a clarified role for the nurse in the milieu.

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MILIEU THERAPY is an interdisciplinary theoretical and clinical approach to inpatient psychiatric treatment in which the total environment is thought to have therapeutic potential. Each event in a milieu may be viewed therapeutically; for example, an event may provide an opportunity for a staff member to encourage a patient to take a constructive risk, to offer praise for a job well done, to assist a patient to solve a problem, to gain insight into a situation, to provide alternative ways of coping, or to just allow the patient to be alone. The theory of milieu therapy has clearly passed one test of its usefulness, that it has been adopted by others (Meleis, 1985). Despite many changes in psychiatric treatment and in social and economic conditions, aspects of milieu treatment are currently applied in most inpatient treatment settings, including short stay. However, much has been written about the need to update theoretical and clinical milieu approaches in light of these changes. Current patterns of inpatient treatment include budget constraints, emphasis on streamlining patients’ return to the community, the use of pharmacological agents, and increasing numbers of seriously ill, dangerous, and difficult patients in inpatient units; these will continue to characterize general hospital psychiatric settings for some time (Guthheil, 1985). Additionally, many current settings in which milieu principles are applied are short stay units, and milieu treatment was developed in long-term settings. These current settings may have different goals than the settings in which milieu treatment originated. Steiner, Haldipur, & Stack (1982) describe three short stay units that purported to ascribe to therapeutic milieu ideals but whose characteristics did not match national therapeutic milieu norms, and suggest that milieu principles could not be implemented in short stay settings. However, it is possible that short stay units may require a unique adaptation of milieu concepts that accommodate the limits of short stay settings but are still based on classic therapeutic milieu concepts. Although current treatment trends may seem incompatible with the original tenets and applications of milieu therapy, the assumption of their continued relevance serves as the basis for this report.

Theory by nature is tentative and subject to change as new knowledge is added to the field in question and as cultures and values change (Hardy, 1973). However, classic theory contains information that may be extremely useful to guide that process. Thus, to render the theory more useful to present settings, current patient needs, the strengths and limits of current settings, and the concepts particular to the more classic theories should be considered (Dickoff & James, 1988; Dickoff & James, 1989; Schmitt, 1983; Stevens,
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1984). In this way, useful aspects of the theory can be incorporated to improve the effectiveness of what is used in practice, and expertise and knowledge acquired in practice can guide the further development of theory. The purpose of this report is to adapt milieu therapy to be useful and relevant to current nursing practice settings to maximize its effectiveness and to guide the development of strategies and research to assess that effectiveness. Although concepts of milieu therapy may be useful for other areas of nursing, e.g., physical rehabilitation units, geriatric care settings, and pain clinics, the focus of this report is acute, short stay, inpatient psychiatric units.

Many investigators have suggested methods of theory analysis and possibilities for their use. The theory of milieu therapy has been analyzed by the author using guidelines provided by Walker and Avant (1983). However, Walker and Avant (1983) state that although theory analysis may show what is missing in a theory, it cannot generate new information. Toward that purpose Schmitt (1983) has suggested steps useful in rendering a theory more useful to nursing; they have been used in this report to update the theory of milieu therapy to current treatment settings. Some of Walker and Avant's analysis steps are included, however, to add clarity and to enrich the generative process.

HISTORY

The historical context and development of a theory may provide useful information toward understanding its content and applications (Walker & Avant, 1983). The following brief history reviews the development of the classic milieu approach and the origin of the three main purposes or goals of milieu treatment. As summarized by Saifnia (1984) and Devine (1981), milieu treatment can be traced as far back as the 1700s, when Dr. Philippe Pinel found that Paris asylum inmates were less violent when they were free to move around. Early Quakers expanded this "moral approach" and later established several hospitals in the United States. During the nineteenth and early twentieth centuries, these ideas were nearly lost as the medical model and early Freudian practices became prevalent. Emphasis was placed on intrapsychic factors and hospitals became a place where patients waited or prepared for treatment. This trend reduced many hospitals to more regressive and controlling environments.

Sullivan (1931), followed by Menninger (1939), noticed that some patients did not behave psychotically when certain persons worked with them. Menninger began to identify and then prescribe certain attitudes to be held by staff members. Probably the best known early milieu approach was that of the therapeutic community, developed by Maxwell Jones (1953). One of the main principles of his approach was to adapt the power structure of a unit so that authority was used to facilitate a social democratic atmosphere. This new use of authority, traditionally held by physicians, changed relationships between staff, physicians, and patients, and was a revolutionary concept at that time (Wilmer, 1981). The power shift was based on the assumption that persons who worked closely with patients on a day to day basis should have the ability to make some decisions and recommendations about the patient's care. Patients were also encouraged to take responsibility for their own treatment, with input into their own treatment process and outcome. Many units used a process of patient government to provide patients with an experience of responsibility and participation in their own treatment and the lives of others. However, to be effective this redistribution of power must be clarified and authorized (Cumming & Cumming, 1962). Physicians and other directors of the unit must authorize and encourage the staff to make decisions on a daily basis and, yet, be available to step in when needed for expert and other decisions. The authorization and clarification of this responsibility, however, does not always occur; Herz, Wilensky, and Earle (1966) caution that redistribution of power may cause role confusion that is antitherapeutic for patients.

TRADITIONAL TREATMENT GOALS

With time, three major treatment goals have been associated with milieu therapy, toward which the redistribution of power was one strategy. One goal was that of resocialization, emphasized by Jones (1953). Resocialization occurs when patients learn new, more positive ways of relating to themselves and others through role modeling and learning about unmet needs or defensive reactions (Jones, 1953). Another goal of therapeutic milieus has been that of ego development, discussed by Cumming and Cumming (1962) in their well known work, Ego and Milieu. Their perspective is that a patient's damaged ego can develop if he or
she encounters small manageable crises in a controlled setting, such as within a therapeutic milieu. If the crisis is manageable, and he or she has adequate available support and assistance, the patient will master the situation, and will gain in ego strength and coping ability.

A third goal of a therapeutic milieu was to prevent the regressive effects of hospitalization (Cumming & Cumming, 1962) that can have the opposite effect of ego development. For example, an over-protective or controlling environment can undermine existing strengths, weaken coping abilities, and resocialize people in a negative way; a therapeutic milieu seeks to prevent that process. Although there is controversy over how much patients should or should not be allowed to regress in an inpatient setting, prevention of regression remains an important consideration in milieu treatment.

MAJOR CONCEPTS

Various investigators have suggested concepts basic to milieus; these are combined in this report in such a way to highlight those most relevant to nursing and to the previously described therapeutic goals. Concepts that facilitated the attainment of the previously mentioned three goals are: containment, support, validation, structured interaction, environmental arrangement, and open communication. Enough of the concept definitions will be presented to convey the richness of their impact on treatment, which should be considered as the theory is updated.

Containment

This refers to a process that "sustain[s] the physical well being of patients and remove[s] the unaccepted burdens of self-control or feelings of omnipotence.” (Gunderson, 1978, p. 328). Some means to achieve this are provision of food and shelter, and safety and treatment measures such as seclusion, restraints, screened windows, locked doors, and medical care. In other words, patients are able to feel safe because their illness will not overwhelm the staff or treatment facility.

Support

This refers to purposeful efforts by staff to enhance the patients’ self-esteem and to help them feel better about themselves. Support includes attention, praise, and reassurance, helping patients to apply coping methods, and providing education and direction. This type of support stems from the “moral treatment” philosophies of early milieus and remains important in many present day programs (Gunderson, 1978). However, Gunderson points out that too much support may confirm a sense of inadequacy and dependence, fostering the feeling that the patient is unable to cope on his own, and thus it can be destructive and too regressive if applied too liberally. This is especially true for some patients. Therefore, the amount of support is a consideration for optimal care, and withholding support is sometimes needed to prevent too much regression.

Validation

Validation refers to those processes that affirm a patient’s individuality (Gunderson, 1978). Patients can receive validation, for example, through individualized treatment programs, staff’s recognition of their need to be alone, from one-to-one talks, or encouragement to function to their full capacity. The staff can validate patients by viewing and tolerating patients’ symptoms and failings as meaningful personal expressions. Gunderson notes that such validation requires a staff to have sensitivity, skill, and the ability to tolerate uncertainty.

Structured Interaction

Structured interaction (Saifnia, 1984) is a broad concept that refers to the structure built into unit processes and treatments to meet the patients’ individual and collective needs for both structure and interaction. Its function is to allow patients to interact with other patients and with staff in a way that is useful to them. Its scope ranges from the frequency and content of formal therapeutic interactions, such as community meetings and other therapeutic group treatments, to prescriptive attitudes staff convey when working with patients. These latter attitudes have been defined by Menninger as indulgence, flexibility, passive or active friendliness, matter-of-factness, casualness, watchfulness, and kind firmness (Menninger, 1960). Structured interactions also require a consideration of time elements, especially important to today’s shortened length of stay. The timing of interventions and also the length of time interventions are used are relevant in determining the potency of interventions (Rasinsky & Pasulka, 1980). Some investigators also identify structure
and interaction as two different variables (Gunderson, 1978), which would help clarify differing patient needs. For example, a psychotic person may need high amounts of structure and small amounts of interaction. Yet, another aspect of structured interaction is attention to developmental needs of patients. The environment and activities are tailored for different ages and developmental needs of patients; for example, adolescents are provided with age-appropriate activities, as are elderly patients. One expected outcome of successful structured interaction is the patient's sense of involvement in the milieu.

Open Communication

Another important concept in many milieus is that of open communication, which refers to two ideas. One is that information about patients is shared among the staff and sometimes between patients through group interaction, resulting in larger numbers of staff and patients knowing about the patients (Saifnia, 1984), and the need to reinforce unit-based confidentiality. Two, it also refers to the practice of direct and open communication between staff and other staff, and between staff and patients. This facilitates the therapeutic work of the unit, and provides role models for the development of more constructive communication in patients.

Arrangement of the Patient Environment

Another concept related to interaction that is thought to facilitate both resocialization and ego involvement is the arrangement of the patient environment. Cumming and Cumming (1962) recommend it to be arranged so that optimal interaction would be encouraged between patients, and between patients and staff. Available work areas and open areas with various activities and tasks to choose from are helpful to that end. This again facilitates interaction, problem solving, and enables opportunities for patients to encounter small successes through their participation in their surroundings. Cumming and Cumming (1962) state that the environment of a milieu should be pleasant but never appear too "finished," that there should be some unfinished task left to be accomplished, so that patients will be drawn into interacting and making decisions about the environment.

Ties With Family and Community

Another aspect of perhaps more recent milieus that has relevance for nursing is the recognition that treatment of the patient must consider his or her ties with family and community. For support and follow-up after the patient is discharged, treatment at community mental health centers is ideally coordinated with inpatient treatment. Family work occurs within the inpatient setting in many facilities also, to further facilitate patients' progress and to treat the family system in which he/she lives.

The traditional concepts have been organized in a dynamic way by dividing them into (1) components, and (2) strategies of milieu therapy (Wilson & Kneisl, 1979). Then, their relationship to patient change and hospitalization outcome has been proposed as diagrammed in Table 1.

Components, or the structural aspects of a milieu include the physical arrangement and setting, including a developmentally tailored and "unfin-

<table>
<thead>
<tr>
<th>Table 1. Understanding the Traditional Theory</th>
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<tr>
<td>Unit Components (Structure)</td>
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<tr>
<td>Physical arrangements and setting</td>
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<tr>
<td>Structured interaction routines, rules, rituals</td>
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<tr>
<td>Staff attributes and role of the nurse</td>
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<tr>
<td>Open communications</td>
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<tr>
<td>Unit based confidentiality</td>
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<tr>
<td>Liaison with community, family</td>
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<td>Containment-seclusion, etc</td>
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ished task" environment; structured interactions such as the routines, rules, and rituals e.g., admission procedures, community meeting times and formats; attributes and roles of nursing and other staff; the unit based confidentiality portion of open communication; the liaison with community mental health centers; and those fixed aspects of the unit that provide containment, such as meals and seclusion rooms.

Strategies, or processes and content, include the redistribution of power, the process and content of structured interactions, including attitude prescriptions, the role modeling portion of open communication, interaction with families, and containment processes such as limit setting, and support and validation.

Thus some aspects of the concept of structured interaction apply to both the component and strategic portions of milieu therapy. For example, the concept of open communication consists of two parts, that of confidentiality and style of communication. The unit-based confidentiality portion could be said to fit as a component, and the style of communication (also used for role modeling) as a strategy. Family and community involvement could fit into either category, depending on whether one was describing a structural arrangement with a community mental health center for referrals, or the referral and interactive process itself. Gunderson’s (1978) concepts of support, interaction (involvement), and validation are included as strategies, because staff could titrate the application of those interventions according to the needs of the patient.

The concepts of acquisition of new skills and behaviors (resocialization), and ego development are goals of the milieu treatment. Relationships between the concepts have been diagrammed as follows (Table 1): the strategies of milieu therapy, occurring within the structural components, result in the outcomes of resocialization and ego development, manifested by improved functioning in personal, family, and community and work relationships. These changes are thought to occur through the mechanisms of insight, conformance to peer pressure, and the experience of small, manageable crisis resolutions.

**ROLE OF THE NURSE**

The role of the nurse has also changed with the advent of short stays and other treatment changes. Historically, the nurse was encouraged to be a spontaneous and active participant in the hospitalization of the patient, and was described similarly in both the resocialization and ego restitution oriented methods. Jones (1953) described the role of the nurse to be a supportive, noninterpretive one unless the nurse was working closely with the physician, but acknowledged that with more training, the nursing role would grow more complex and include more advanced therapeutic activities.

High regard for nurses and other staff working in the milieu was expressed by Cumming and Cumming (1962, p. 146), who found that there existed a "body of specific nursing skills that can affect progressive improvements in the day-to-day behavior of large numbers of mentally ill patients," and that attention to these skills had largely been obscured by attention to the medical model and the development of psychoanalytic treatment. They recommended that the most important aspect of a staff in a therapeutic milieu is having a heterogeneity of personality styles, each possessing humanity (caring), energy, spontaneity, and a complexity of roles and abilities in their own lives to enable them to add to the ego strengths of the patients. Leach (1982) commented that the role of the nurse in the milieu is often not defined by a "nursing role" so much as by the personality, talents, and skills of each individual, in each setting. Currently, however, nurses with advanced training often work in advanced therapeutic roles in the milieu, as family or individual psychotherapists, both in inpatient settings and/or as part of outpatient follow-up care. Shortened lengths of patient stay, and more advanced preparation in general have made nursing roles more complex. The reworking of the theory in this report adds clarity to that role.

**THE TRANSFORMATION PROCESS**

"Prescriptive theory should designate the prescription and its components, the type of client who should receive the prescriptions, the conditions under which [it] should occur, and the consequences of applying the prescriptions" (Meleis, 1985; Woods, 1988, p. 128). While the original goals of milieu therapy were appropriate in those settings in which they were developed, current patient needs are different. Patients’ needs in an inpatient short stay setting are extremely varied. In addition, the options for clinical interventions dur-
ing short stays may be quite limited. Psychosocial change by nature is slow (Mosher & Keith, 1979), and "... brief hospitalization severely limit[s] the opportunities for using a structural change model or for attempting any treatment method other than an adaptational approach." (Kleespies, 1986, p. 509) However, within the shorter time frame there are still different options. Instead of lasting personality change, the goals can include crisis intervention, symptom stabilization, restoration of previous functioning, and longer length of community tenure before rehospitalization.

Schmitt (1983) suggests that theories can be more useful to current nursing practice if one determines patient needs, the goal of nursing action to meet those needs, and the means of nursing action toward those needs. Using those suggestions, and with the concepts of milieu therapy identified, what are now the current patient needs, specifically those patients in short stay inpatient units? Although Herz (1981) and Kleespies (1986) recommend identifying specific needs of individual units and patient populations, some needs are generalizable across most short stay inpatient units and are described below.

There is a need for structure. This might be a set of defined expectations or a guide as to how a patient will divide his time, in what spatial-temporal framework the patient will be provided treatment, and to what rules and regulations the patient will be expected to conform. Structure seems particularly relevant for psychotic patients (Herz, 1981) but others need structure as well. For example, Yalom (1985) writes that the degree to which an inpatient therapeutic group is successful often depends on the amount of structure that is provided by the leader.

Other patient needs seem to be an opportunity for some participation in their own treatment and conditions of the unit, and a need for limits, safety, and controls. Opportunities to interact with staff and patients are needed to facilitate involvement, and to maximize the possibility of their both receiving and offering support, to enable them to feel useful, to gain information about coping abilities, and for exposure to role modeling.

There is need for short-term treatment relative to a patient's difficulties and abilities. Again, as opposed to long-term intervention, there is more emphasis here on crisis intervention, the provision of support and structure to prevent further regression, restoration and facilitation of coping abilities and provision of referrals for further treatment, rather than providing opportunities for further treatment, resocialization, or personality reorganization.

After identifying patient needs, Schmitt (1983) next suggests identifying the goal of nursing action in meeting those patient needs. In other words, what patient outcomes would enable nurses to know if those needs were being met?

In light of the shorter duration of hospitalization, the goals for which nursing staff can strive include improvement of patients' acute conditions for which they have been hospitalized, and their movement, however slight, toward an overall treatment process, whether that be psychological growth and development, increased coping ability, or adjustment to a chronic mental illness. Short term treatment goals include (1) the patient has a resolution or lessening of symptoms for which he or she was admitted, such as depression, psychosis, suicidal ideation; (2) the patient's coping mechanisms have been increased or at least restored to prehospitalization levels; (3) the patient has a sense of hope and of direction for his/her treatment after discharge; (4) the patient has a sense of confidence in health care providers; and (5) the patient has access to and knows about appropriate available resources.

What nursing actions would be needed or proposed to meet patient needs and to facilitate those outcomes? The nurse would:

1. Provide limits and controls as needed and provide structure and safety for the patient in the milieu and on the unit. This refers to the structure of everyday routines such as meal times and routine meetings as well as patients' individual needs for structure, which will be described later under treatment and therapeutic activity levels.

2. Arrange milieu treatments on the unit that are appropriate for the patient's needs in the time frame available. Treatments would be developed based on the assessment of needs of both individual patients and the patient population on that unit. i.e., relaxation groups, or drug and alcohol groups, open discussion groups, medication groups, focus groups for disorganized individuals, etc. Therapeutic attitude prescriptions would be included here as well as provision of support, validation or other specific approaches, such as time out schedules for over-stimulated patients, and specific interventions. This should be measurable.
through documentation on care plans and through behavioral observation.

3. Maintain a therapeutic activity level—through both spontaneous and planned activities. These activities would include those routine and more formally therapeutic activities but also spontaneous and “for fun” activities. These promote positive emotional interactions and a sense of emotional connectedness among patients and between patients and staff. All interactions would be conducted according to patients’ abilities that may require adjustment of the stimulation levels in the milieu. Patients who have inadequate stimulus barriers, i.e., those who are psychotic, manic, or who have organic or paranoid disorders (Jeffrey, 1985), may need stimulation levels decreased to the point where they may need to be secluded.

4. Facilitate open communication between patients and other patients and staff. In a short-stay setting the issues discussed may not be very deep or complex but open communication would still occur and be demonstrated through role modeling and discussion of issues relevant to the entire milieu such as when a patient has been put into restraints or seclusion. While traditional milieus often subscribe to a policy of open expression of feelings, including anger and aggression, in short-stay settings, although feelings are validated and acknowledged as part of human and also of therapeutic process, the emphasis is on communication, which is practical and supportive and aimed toward achievement of the other therapeutic goals.

5. Coordinate interdisciplinary and/or nursing care planning. This planning would provide a basis for the provision of consistent, goal-directed patient care in the ever changing milieu. Input into the plans is ideally discussed by all members of the health care team, and the plans are implemented by appropriate members of the staff. Written care plans also provide documentation and can be used for measurement purposes.

6. Participate in or coordinate the development of those policies necessary to ensure the delivery of these actions. These would be realized through working administratively or providing input into administrative processes and unit policies relevant to all aspects of the milieu.

These nursing goals and actions should be within the realm of nursing influence and practice in most hospitals today. If not, nurses need to work to influence those areas in their work settings.

The relationship of nursing actions to patient needs and outcomes have been diagrammed in Table 2. Patient needs for structure, safety, participation and involvement in the milieu, increased coping ability, and specific treatments relevant to their needs are met through nursing actions of providing structure, limits and controls, maintaining therapeutic activity levels, facilitating open communication, and arranging and providing treatment experiences for patients. These nursing actions assist patients to achieve symptom resolution, increased coping, hope and a sense of direction for their treatment, a sense of confidence in health care workers, and willingness to engage in treatment after discharge.

| Table 2. The Theory as More Useful to Nursing in Short Stay Settings |
|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| **Patient Needs**           | **Nursing Action**          | **Mechanisms, In-Hospital Goals** | **Hospitalization Outcomes** |
| Structure, safety, limits and controls | Provide or coordinate structured activities, limits, control as needed | Patient involvement in milieu | Symptom resolution |
| Treatment relative to patient needs, in addition to “milieu approach” (can include support, validation containment) | Set up appropriate treatment experiences for patients | Meaningful interaction with others | Increased or restored coping |
| Opportunities for participation and interaction with others | Maintain therapeutic activity levels | Realistic attention to treatment and other needs (can include validation, support, containment) | Hope, sense of direction for treatment |
|                            | Facilitate open communication | Participation in own treatment | Willingness to engage in treatment after discharge |
|                            | Coordinate, participate in policy development and implementation |                           | Sense of confidence in health care providers |
|                            |                             |                           | Knowledge of resources |
vestigator’s clinical and educational experiences, they were identified immediately after a formal theory analysis of the traditional theory. Thus the traditional theory and its history served as a rich backdrop for the transformative process. Thus, true to the intent of this transformative process, which was to combine aspects of old and new, the transformed theory can still be associated with the traditional one in many ways. When comparing Tables 1 and 2, much of the “current” theory is similar to the traditional theory of milieu therapy, but has been tailored to short stay settings. The list of current patient needs can be associated with many of the former basic concepts. And nursing actions in the newly rendered theory are those actions directed toward achievement of the current patient needs, but they address many of the former strategies and components. Thus the old concepts have been reworded and reorganized in a more practical and action oriented manner but are still present in the theory (Table 3).

Other additions to the theory have occurred also. Table 2 also shows that by incorporating nursing actions toward patient needs, the nursing role has been clarified, and short-term patient goals have been substituted for long-term goals. These short-term goals are not different goals so much as “mid-range” or even beginning goals that need to be attained before the long-term goals can be achieved. The former hospital goals of resocialization and ego development may still be appropriate, but over a much longer time period than one short stay hospitalization. Such goals could be possibly still be considered, implicitly, over a longer course of combined inpatient and outpatient treatment, or for patients with repeated hospitalizations. But these longer term goals would be secondary to current short-stay hospitalization goals.

**TESTING AND OPERATIONALIZING THE THEORY**

This report has demonstrated the continued usefulness of the theory of milieu therapy for nursing practice and demonstrated the process through which the theory was updated to be relevant to current treatment settings, by taking into account both the earlier richness of conceptualization, and current trends in treatment philosophies and nurse preparation. Although the usefulness of milieu principles will no doubt continue to be evident through their continued application in practice, further refinement of the theory will be accomplished through research and testing of associated patient outcomes. The concepts of milieu therapy have been found to be difficult to quantify, although three instruments have been developed to measure more classic milieu qualities and characteristics: The Moos Ward Atmosphere Scale (Moos & Houts, 1968; Price & Moos, 1975) the Ward Initiative Scale (Houts & Moos, 1969), and the Patient Perception of the Ward Scale (Graham

**Table 3. Linking the Transformed Theory to the Traditional Theory**

<table>
<thead>
<tr>
<th>Patient Needs</th>
<th>Related Basic Concepts</th>
<th>Nursing Actions</th>
<th>Mechanisms, In-Hospital Goals</th>
<th>Hospitalization Outcomes/goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structure, safety, limits and controls</td>
<td>Containment, support validation</td>
<td>Provide or coordinate structured activities, limits, and controls as needed</td>
<td>Patient involvement in milieu, Meaningful interaction with others, Realistic attention to treatment and other needs, Redistribution of power—participation in own treatment</td>
<td>Symptom resolution, Increased or restored coping, Hope, sense of direction for treatment, Willingness to engage in treatment after discharge, Sense of confidence in health care providers, Knowledge of resources</td>
</tr>
<tr>
<td>Treatment relative to patient needs</td>
<td>Structured interaction, Open communication, Support, Validation, Containment</td>
<td>Set up appropriate treatment experiences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opportunities for participation and interaction with others</td>
<td>Structured interaction, Physical arrangement, Open communication</td>
<td>Maintain therapeutic activity levels, Facilitate open communication, Coordinate, participate in policy development and implementation</td>
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et al., 1970). A number of the factors identified on these scales are similar to concepts described in the milieu literature. The most recent recommendations for milieu research indicate needs for identification of specific treatment factors impacting patient outcome for specific populations and diagnoses, including length of stay (Herz, 1981; Kleespies, 1986). Of the concepts in the reworked theory, the concept of structured interaction seems most immediately measurable: attitude prescriptions can be measured in terms of frequencies, as can other interventions with both behavioral observation and documentation on nursing care plans. The numbers of community meetings and other groups can be measured, as well as their type and their methods.

Thus with continued development, specification, and refinement, the application of the theory of milieu therapy to short stay settings is expected to add to our repertoire of useful nursing theories, which in turn will strengthen the professional foundation of our practice and enhance patient outcome. Classic milieu treatment concepts have had lasting impact; our challenge now is to continue to question and update them, and to verify that work through research.

ACKNOWLEDGMENT
The author thanks Caroline M. White, Dr. P.H., for her guidance in preparing the manuscript.

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