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Trainees' forum

The Henderson Hospital – a trainee's experience

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In this issue of the *Psychiatric Bulletin* (pp 72–76), Dolan & Norton discuss the need to protect specialist psychiatric units such as the Henderson Hospital. They describe a variety of functions of these units, but only make brief reference to training. I would like to describe my six months in psychiatry spent as a registrar at the Henderson Hospital. My enjoyment of the placement may not be synonymous with the Henderson serving an important training function, but I hope that I can explain why the two may be linked.

As Dolan & Norton describe, the Henderson provides in-patient group psychotherapy in the context of a therapeutic community (TC). Most often the patients (usually called 'residents') have well-established major personality disturbances. The working week is highly structured. For the staff, the day starts with a handover. This is followed by a community meeting and a further staff meeting to discuss the community meeting. The latter half of the morning varies between small groups, cleaning and review meetings. The afternoon usually consists of a 'work group', chosen from cookery, maintenance, gardening and art.

For a registrar, arriving from an acute in-patient unit, the experience is disconcerting. Familiar roles are stripped away. On an acute ward, you have the role of reviewing medication cards. The Henderson does not permit residents to have prescribed psychotropic drugs. An easy, but exclusive, role is lost. On an acute ward, you can admit patients, review mental states, offer individual psychotherapy, write up the notes, and dictate discharge summaries. In ward rounds you are the centre of information and organisation. At the Henderson none of these quite apply. Residents do not have admission summaries in the same way as on the general psychiatric ward but in the first three weeks a comprehensive report is made of background history, observations on functioning within the community group as a whole and issues arising from the residents' group are highlighted to give a direction for further therapeutic intervention. Mental states are not the prerogative of the medical staff. Individual therapy is largely avoided and formal continuation notes are largely replaced by observations on the interaction of the individuals within a group. Ward rounds do not exist in the formal sense but all discussions of residents involve the full diversity of staff and take place with different staff members in different locations several times during a day. More roles lost.

I joined the cookery group. Among the residents was an army-trained chef, and I learnt a lot about how to resuscitate a failed quiche. I certainly wasn't able to teach anyone anything about cooking. What is left for the registrar? The answer is that the registrar has no exclusive role. Along with other staff, the registrar functions as a therapist in community meetings, small groups and work groups. Most of the other staff have more experience of this role, and hence there is a real sense of getting trained through an intensive experience of large and small group psychotherapy in the context of sociotherapy.

I found the end of the structured day difficult. It took weeks for me to go home at this point – to realise that there was nothing more for me to do. In other jobs I have complained at having too much responsibility. Such a marked reduction in my obvious role and responsibilities wasn't, however, all good news. There is no doubt that I felt uncomfortable at my loss of importance. Considering the nature of the residents, it was surprising how infrequently I went home and worried about what was happening overnight. I had to go home and worry about publications I hadn't got and other important issues!

Rapoport (1960) describes four central principles in the operation of the TC: democratisation; permissiveness; communalisation; and reality confrontation. In the description above I have hinted at elements of democratisation within staff functioning, but democratisation extends well beyond the staff. The residents certainly do not share equal power with the staff, but they are centrally involved in important decisions. People are considered for admission in a process of interview by a committee of staff and residents. The decision to admit is then made by the same committee with all members having equal voting rights. Residents are often discharged at a point they do not seem to choose. A limited number

of behaviours lead to automatic discharge, but for the most part boundaries on behaviour are 'permissive'. Discharge decisions are made in community meetings, once again with staff and residents having equal voting rights. 'Role-reversal' operates powerfully and effectively.

The hospital runs visitors' days and provides outside teaching about TCs. Both staff and residents participate on all these occasions. As in decisions about admission and discharge, the residents are fascinating to watch. The same resident who took an overdose last week can be seen explaining to another resident why such behaviour should lead to discharge. The same resident at a visitors' day can be seen explaining the advantages of looking at his own behaviour 'from the outside'. The hypocrisy could be amusing or irritating, but overall I was constantly surprised by the potential insight of the residents.

With involvement in decision-making, the residents inevitably take on responsibility. Some responsibilities are indicated above, but there are more. Residents are involved in chairing meetings, providing feedback on groups, setting up rotas to look after other residents threatening to harm themselves, going to casualty with staff when another resident has harmed himself. Morrice (1979) elaborated Rapoport's basic concepts stated above. He suggests that reality confrontation is to tell the truth in love (not in hostility, as the term often suggests). There are several elements here. Firstly, telling patients the truth. In group settings and reviews (which the resident in question attends) I found staff at the Henderson more honest in giving feedback to patients than I have previously experienced. Secondly, telling the truth in love. The phraseology is a bit strong, but I think that this also happens at the Henderson. This seems to be made possible by a number of factors; being honest, comprehensive staff support and boundaries minimise the necessity for aggression towards the residents.

A previous article in the *Bulletin* (Wells, 1984) concluded that working in a modified therapeutic community for disturbed adolescents could be both useful and relevant to the training of junior doctors. It may seem that I have made a case for not including a placement within a TC on a registrar training rotation – a doctor is unnecessary to the working of the unit. I certainly don't believe this to be true. Firstly, I suspect that any unit dealing with such high levels of psychopathology needs medically trained staff to be involved to fulfil their more traditional role in rare crises, or at least to deal with the fantasy of such crises. There is thus a case for training psychiatrists eventually to take consultant roles within such units, or modifications of such units. Secondly, I believe that working in a TC can give doctors a new perspective on responsibility.

My own experience taught me a number of lessons. Firstly, extremely difficult patients can be managed without medication and can actively participate in their own treatment. Secondly, groups can be used to make decisions, and good decisions at that. However, the most important lessons were those about responsibility. A medical training (and perhaps the rest of our background) lends us an omnipotence that can carry a potentially crippling sense of responsibility. The Henderson taught me that it is possible for a doctor to share responsibility with other staff (and *vice versa*) and that it is possible to return responsibility to the patient (or failing this for the doctor not to accept responsibility for all problems brought to his door). Not accepting inappropriate responsibility minimises the need to feel resentful towards patients subsequently. Of course, I knew all these things before, and a large part of training in psychiatry centres around these issues. However, theory and practice differ. Nowhere else have I had such an intensive and clear opportunity to look at responsibility, and in practice unburden myself.

Dolan & Norton argue that the Henderson's primary role is the provision of a treatment service. This may be so, but I'm not sure that it should be. Whiteley (1979) argues that "The TC today finds itself the victim of its own success. The general ideas have been taken up in hospitals and in society at large but the means have become separated from the meaning. In many cases what has purported to be a community democracy model is no more than a superficial gesture towards open communication and power-sharing, without real understanding of the principles involved". The Henderson operates a relatively pure TC model, which limits the patients for whom it is applicable. The purity of the model, however, is important in providing a training experience for a wide variety of staff that clarifies the issues involved. *Working for Patients* (Department of Health, 1989) emphasises service provision, and rather neglects staff training. I believe that we should still be able to justify the existence of certain units on the basis of providing specialist training. The provision of an important direct service to patients can be a secondary function. Some members of the 'TC movement' argue that the model can have almost universal application in the management of psychiatric patients. This is not my belief, but psychiatry in general still has a lot to learn from the movement and this can be best achieved by staff having some direct experience of a relatively pure model.

For six months after leaving the Henderson I worked on a 'locked' ward in a large psychiatric hospital. Most of the patients I saw would never be candidates for the Henderson, but some were in essence the same patients. However, these patients had ended up on Sections of the Mental Health Act

and often received medication to control their behaviour disturbance. The admissions were usually perceived in a negative light by both staff and patients. Since then I have continued to see the same patients in other settings – out-patient clinics, prisons and casualty departments. It has usually not been a pleasant experience. The patient has often been intoxicated, threatening himself or others and I have felt a sense of responsibility, or had responsibility placed on my shoulders by relatives or other staff. The responsibility was, in part, mine to accept or reject. My acceptance of the responsibility has sometimes been destructive for both me and the patient. A refresher six months at the Henderson might well prove useful!

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Style matters

The nuts and bolts of writing papers

Number 2. Repetition

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Repetition recurs recurrently in scientific writing. To my mind an introduction to a paper should be just enough to get people thinking about whatever it is that they are meant to be thinking about. Too many papers begin with an introduction that ends up as a discussion, and too many discussions begin with an introduction. Too many papers introduce the methods in the introduction, they recap the methods and results in the discussion, and they discuss what was discussed in the introduction in the discussion. Conclusions often conclude with what was concluded in the introduction, in the results, and in the discussion. And don't forget that the summary has said all the interesting stuff in four lines.

The point to remember is that your readers are not only busy people – they are also bright, and they might not appreciate being told everything twice.

Tautology

The other aspect of repetition that needs mentioning is tautology. There are many examples of generally used tautologies, such as 'equally as good as', a 'new innovation', and 'refer back to'. However, there are some tautologies often used in scientific papers which are not so much sloppy as a devious means of sounding technical. Two examples will probably suffice.

'Period' is often added to a length of time. A four-week period is four weeks however you look at it, but many writers prefer to say that a drug was administered over a four-week period than that the drug was given for four weeks.

'Personality' is a more particularly psychiatric example. I sometimes read that, at interview, a patient had a shy and retiring personality, as one might have a shy and retiring pet hamster. Be bold! (I refer here to the writer, not the patient, or indeed the hamster.) Say that the patient was shy and retiring, or why not even leave out 'retiring' for all but the over-60s?

Practical advice

Before you come to the last draft of a paper, read it through and cross out as much as you possibly can. Delete words, delete references, delete sentences, delete headings, delete paragraphs! If you can't bring yourself to do it, having put so much work into writing it, invite a friend round to your office for a bit of crossing out. Remember that an editor will be more ready to accept a borderline paper if it does not take up too much space, and that a referee is bound to mention that a paper lacks necessary detail should you have gone too far.

Next month: Style and grammar.