TRAINING IN SOCIAL PSYCHIATRY AT WARD LEVEL [1]

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With the increasing interest in the social environment of the patient, the role of the ward psychiatrist becomes more complex. It is not enough to be a competent diagnostician and individual therapist; he must now learn how to recognize and modify the social organization and culture of his ward, as well as the complexities of group treatment. Ideally, this would entail exposure to the teaching of experienced psychiatrists and social scientists. It is rare for a resident to get social science teaching outside a university hospital or clinic. However, the growing interest in the social dimension in mental hospital psychiatry is manifested by relevant literature, to which the psychiatrist in training is increasingly referring (1, 2, 3). Nevertheless, it seems to me that whatever training skills are available, the most effective way of teaching this aspect of psychiatry is in the ward situation.

This can best be accomplished by a daily meeting of all personnel on the ward, both patients and staff. If this is immediately followed by a "post mortem" of about the same duration involving all staff members, then there is an opportunity to examine the response of the various personnel with different skills, expectations, prejudices, etc. In this setting, it is possible to discuss the perceptions and feelings of the staff retrospectively in relation to the ward meeting and also to examine their interaction during the staff meeting. I do not want to discuss here the phenomena which one associates with the ward meeting as this will be discussed elsewhere(4), but would like to consider the "post mortem" staff session.

Let us assume that all personnel who come in contact with the patient in a therapeutic role will be present at both meetings. In the "post mortem," they will, in varying degrees, be able to express both their analyses of certain aspects of the meeting and their subjective feelings. If we take a frequently recurring problem, such as authority, the aides may perceive this in terms of their own desire to conform to a strict authority system. The cleanliness of the ward, the observation of smoking rules, the avoidance of incidents, etc., are necessary if they are to avoid undue anxiety. In this context, they will tend to express, directly or indirectly, views which support the maintenance of patient discipline. At the other extreme, the doctors, if they have had considerable experience in examining the social interaction on a ward, may perceive untidiness or dirt on the ward as symptoms of disorganization among the patients and want to examine this as a form of communication. To do this at all skillfully, the anxieties of the aides will have to be given due consideration, and the realities of their position faced frankly. In discussion, it may emerge that the aides are uncomfortable at ward meetings, which they feel take up far too much of their time, and are responsible in part for the untidiness of the ward. They may point out that continued disapproval from their higher authorities may result in possible loss of employment. This fear may be re-enforced by the fact that their supervisors are themselves not trained in social psychiatry and may apply a value system to their area of responsibility which is at variance with the developing culture on the ward. It may be that a long-term plan involving training seminars with the supervisors will be a necessary adjunct to the effective functioning of the ward if the total ward situation is to be rendered therapeutic. At the same time, it may appear that the anxiety of the aides stems in part from their personality difficulties (relatively inadequate education and lack of sophistication), which hampers them in their role relationship with more highly trained personnel. They may deal with this by denial and rationalization, blaming the frequency of ward meetings and lack of discipline, for the unsatisfactory state of affairs. A situation of this kind is

not infrequent and the mere gain in insight on the part of an aide may not in itself be enough. It takes a long period of education and support, if not of therapy, to tide them over the transition from their previous image of a structured, simplified role to that of a therapeutic one.

What has been said about the role of the aide in a ward problem bearing on authority would apply in different ways to all the roles and role relationships on the ward.

The charge nurse may have particular difficulties in that, by contrast with the aide, she has a relatively higher status and a professional image which implies knowledge which frequently she does not possess. Most R.N.s have been trained in a fairly strict, authoritarian culture and have little experience in the examination of roles and role relationships, the sharing of responsibility, and the concept of group decisions or group treatment. She may resent the loss of her relatively exclusive relationship with the doctor and the staff's examination of her handling of patients' problems. In the "post mortem," it may become clear that when she feels threatened by patients, she resorts to devices such as recommending shock treatment, transferring the patient to another ward, or "regressing" to an authoritarian disciplinary role. Like the aide, she, too, has the problem of a nursing authority structure. She is expected to satisfy the needs of personnel who have no direct contact with the ward and who view things from their own particular nursing perspective. Unless nursing supervisors and the higher echelons of nursing can themselves become identified with ward community treatment programs, then confusion of roles is almost inevitable. The ward views the problems as material for treatment whereas the nursing hierarchy tend to view them as administrative problems, calling for immediate action. One device frequently used by the nursing profession is to transfer a nurse to another ward if there are repeated ward problems. By doing this, of course, nothing is learned from the disturbance on the ward but, from the point of view of administration, the problem is got rid of by transfer.

I have found it possible, even in a large state hospital, to use situations of this kind as learning experiences for all personnel concerned. The director of nursing and her senior colleagues have been extremely willing to participate in seminars involving the ward problems so that even if a nurse has been transferred it is still possible to recreate the situation in retrospect and see what alternative answers could have been found to the problem. Whether this should be done by inviting senior nursing personnel to the "post mortem" meeting or whether it calls for a separate teaching situation is still, I think, an open question, and much would depend upon the circumstances. The essential point is that the ward doctor should be involved so that he is in a position to gain experience in dealing with the different dimensions of the problem. Nurses from the Department of Education may also be involved in this kind of training experience. If they have student nurses on a ward, they tend to teach them in a situation which is removed from the actual ward interaction. If, however, the nursing education personnel themselves become involved in ward meetings and find a functional role for themselves on the ward, they are then in a position to discuss the interactional scene with their students in the "post mortem" meeting and in their own teaching seminars. In this way, their own perceptions of what went on and what they would normally teach their students can be examined by other trained personnel and nursing education puts itself in the position of having a continuous educational experience, instead of tending to become stereotyped. Moreover, the staff meeting is an ideal setting in which to work through some of the problems inherent in the role relationships between medical, nursing service and nursing education personnel. All 3 have a significant relationship with the student nurse and unless a serious attempt is made to work through this relationship, the student may find herself confused and, at times, victimized. What she wants above all is someone to turn to when she is in emotional difficulties with her patients. My feeling is that in the kind of overall training program which we are discussing, she will be able to turn to the charge nurse, to the nursing education supervisor, or to the ward personnel, including the doctor, social work-

er, psychologist, and so on, all of whom should be in a position to understand certain aspects of the problems of nurse-patient relationships on the ward. This implies a degree of role blurring which is perhaps unusual. At the same time, it implies a degree of sophistication through time of all ward personnel which inevitably follows on daily staff meetings when the problems of treatment, ward management, interpersonal relationships, including staff relationships are under constant scrutiny and discussion.

What I have said about the roles of the personnel in direct contact with the patient applies equally to the more peripheral roles, including the social worker and psychologist, whose relationships with patients, whether as social caseworkers or as therapists or group workers, should be discussed freely with the total ward staff personnel. This implies that roles are constantly being modified and that a psychologist or social worker on Ward A need not necessarily have a similar role on Ward B. In fact, it seems a pity if professional personnel become identified with their own professional sub-group rather than with the ward on which they are working. All this implies a considerable degree of skill and sophistication on the part of the ward leader who, at the present time, is usually or perhaps invariably the psychiatrist. There seems to me no adequate reason why this responsibility should continue to rest with the psychiatrist unless he has the kind of training and skill which we are discussing. This leadership role could reasonably be given to one of the other staff personnel provided, of course, that the purely medical matters were left, as they must be, to the doctor.

In order to become competent in handling the various role relationships and ward management problems, the psychiatrist is forced to attempt to examine the problems of the various personnel and see them from not only his own but from the other points of view. Whether group consensus can be seen as a satisfactory way of resolving problems, if indeed it is ever achieved, is an open question, but the attempt to examine problems in various dimensions is a rich learning experience. Obviously, it is much better if this whole procedure is supervised by a social scientist with ex-

perience on a psychiatric ward or a psychiatrist who has had considerable experience in group work and the social science field. Such training will help him to make optimal use of his staff and the social environment generally and where psychiatrists are concerned will be invaluable preparation for a possible future role as a mental hospital administrator.

It could be said that to date residency training in psychiatry has been geared more to the needs of private practice than of mental hospitals. In general, a well-trained psychiatrist should be equally competent in both private practice and mental hospital spheres. At the present time, there is a distinct difference between the 2 types of practice, although this difference should become increasingly less apparent as community psychiatry develops. Training along the lines discussed in this paper can do much to help the doctor who intends to remain in mental hospital practice to make optimal use of his environment. At the same time, it would help the psychiatrist in private practice to be sensitive to the social dimension in such ways as involving the families in treatment, making optimal use of the mental health facilities in the area, and so on. If, as seems probable, the tendency will be for more and more patients to be treated in the community rather than in the hospital, then clearly their supervision will be the concern not only of the community psychiatrist but also of social welfare, the private psychiatrist, the general practitioner, and family care, integrated in a way which has much in common with the practice of social psychiatry at ward level. For such training to be really effective, however, it will be necessary for residency training programs, both in medical schools and in state hospitals, to have both intra- and extramural psychiatric practice.[3] The extramural practice of psychiatry is being stressed at one or two training centers at the present time, e.g., the Harvard School of Public Health and the department of psychiatry at the University of Southern California. Both offer fourth-year residency training in the public health field.

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[3] It is the latter factor which appears to have contributed much to the relatively satisfactory state of current British mental hospital practice.

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