# THE FIRST THREE YEARS OF A NEUROSIS CENTRE

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The aim of this paper is to set down what have been the experiences gained in the opening and running of a neurosis ward, to indicate a few of the problems encountered, and to make one or two tentative suggestions as to how a task of this nature may be approached. The unit was opened in July 1951. It consists of a 20-bed ward block within a comparatively large hospital which exists otherwise for the care of chronic sick or elderly patients. Thus it has been necessary to integrate the unit into a hospital not constructed or administered for the treatment of psychological disability. The hospital is laid out in separate blocks, so that the neurosis ward stands on its own; but it is served by the main kitchen, occupational-therapy department, stores, and engineering, secretarial and other services of the hospital. The district is semi-urban in the outskirts of London and we are half-a-mile from the bus terminus and the railway station. There is a shopping centre at 10 minutes' walking distance from the hospital and in another direction there is ready access to open fields.

The 20-bed ward consists of rooms with 1, 2 or 3 beds in each, a kitchen, dining room, sitting room, games room and other amenities; and there is a considerable area of grassed space where patients may sit outside in summer. Out-patient practice is a normal part of our work and roughly one-half of the medical-treatment time is devoted to out-patients, albeit a majority of the latter have at one time or other been in-patients themselves. A small child-guidance clinic is part of the out-patient service, with a play room in the ward; but this venture is separate from the rest of our work and will not receive further consideration in this paper. There are no in-patient facilities for children—nor could they be satisfactorily integrated within an adult ward—but adolescents are occasionally admitted.

*Staffing.* The staff of the unit comprises one psychiatrist, 2 nursing sisters, 4 staff nurses, and 6 assistant nurses who need not have previous training. In spite of the recent addition of a part-time consultant psychiatrist, the volume of out-patient work is such that the medical staff is hardly adequate. A trained nursing staff of 6 is generous and 5 might suffice, but we have found that there is not scope for more than 3 or 4 untrained nurses. It would be better if junior nurses from a training hospital (general or mental) could come to the neurosis

centre, 3 or 4 at a time for, say, 6 months, as part of their training; but it has not so far been possible to bring such a scheme into operation.

*Admission of Patients.* Patients are admitted from a wide area, mainly urban. Almost all the cases have been referred for consultation to a psychiatrist, who has advised the admission, the primary consideration being that the patient is suitable for treatment in an open ward and capable of becoming socially integrated into the ward community. The patient may be admitted (*a*) because he is too depressed, schizoid or otherwise upset to be living at home; (*b*) an anxious or disturbed patient may require for a time the rest and security which a hospital ward can best provide; (*c*) in-patient treatment is sometimes the best medium in which to undertake necessary physical therapies such as ECT; (*d*) in some cases we feel that an insecure individual will gain from the social contacts and social therapy of the unit; (*e*) in a few instances the necessity for diagnostic investigation justifies admission; (*f*) sometimes a patient is sent to us because he lives at such a distance from hospital or from a psychiatrist that travelling would be difficult.

*Results of Treatment.* During the period under review (2½ years) 222 patients were admitted (Tables I and II), of whom no less than 62 had eventually to be classified as having achieved a poor result, while 15 left against advice and 24 were transferred to other hospitals. In some transferred cases preliminary investigation was necessary and in not a few of those who were unimproved we were able to gain a more or less adequate understanding of the patient's personality and illness. Some of those patients have taught the physician valuable lessons in psychology.

The average length of stay in hospital has been progressively reduced, being 75 days in 1951, 68 days in 1952 and 59 days in 1953. During a 4-month period in 1954, 55 patients were admitted with an average length of stay of 38 days. It is one of our aims to eliminate altogether long periods of residence—above 3 or 4 months—in the ward. The cost is perhaps the principal argument against long terms, but, moreover, there is a tendency for a patient whose stay is unduly protracted to become increasingly dependent on the security that the hospital ward and its associations are providing; and if such a patient's neurosis does not materially improve eventual discharge becomes increasingly difficult. Adverse home conditions and travel 'phobia' are two circumstances that have appreciably added to the length of stay in a few instances. In the main, however, it is initial assessment of cases suitable for admission and subsequent clinical judgment that are likely to be the decisive factors.

## TREATMENT

Social therapy and the inter-reaction of individuals upon each other, whether patients, nurses or doctors and whether singly or in groups, is a central factor in treatment and is highly valued in its own right. Its benefits, subtle as many of them are, are something that the neurosis centre can give to its patients as a distinct contribution to their recovery. Within a group of patients rather more highly selected than our own, Maxwell Jones (1952) studied the mechanics of social therapy in greater detail and depth than would be possible here. Suffice it to say that a few patients seem to have gained all they required from the social milieu of the unit, but that with the great majority

TABLE I. DIAGNOSTIC CLASSIFICATION

| *Diagnosis* | *Total Patients* | *Left against Advice* | *Recovery* | *Appreciable Improvement* | *Poor Result* | *Transferred* | *Special Circumstances* | *Died* |
|---|---|---|---|---|---|---|---|---|
| Schizophrenia and Predominantly Schizoid States | 23 | 3 | — | 3 | 9 | 7 | 1 | — |
| Anxiety States | 76 | 6 | 12 | 33 | 17 | 7 | 1 | — |
| Depressive States | 50 | 4 | 6 | 28 | 6 | 4 | 1 | 1 |
| Hysteria | 45 | 1 | 2 | 21 | 18 | 2 | 1 | — |
| Obsessional or Phobic States | 14 | 1 | 1 | 6 | 4 | 2 | — | — |
| Psychopathic Personality | 9 | — | — | 2 | 6 | 1 | — | — |
| Epilepsy | 3 | — | — | 1 | 1 | 1 | — | — |
| Organic States | 2 | — | — | 1 | 1 | — | — | — |
| Total | 222 | 15 | 21 | 95 | 62 | 24 | 4 | 1 |

TABLE II. SUMMARY OF WORK DONE AND LENGTH OF STAY

| | *Less than 1 month* | 1-2 *months* | 2-3 *months* | 3-4 *months* | 4-5 *months* | 5-6 *months* | 6-13 *months* | *Totals* |
|---|---|---|---|---|---|---|---|---|
| Total | 65 | 63 | 33 | 27 | 12 | 10 | 12 | 222 |
| Left against Advice | 13 | 2 | — | — | — | — | — | 15 |
| Recovery | 6 | 5 | 3 | 4 | — | 3 | — | 21 |
| Appreciable Improvement | 17 | 28 | 20 | 13 | 5 | 4 | 8 | 95 |
| Poor Result | 14 | 24 | 3 | 9 | 6 | 3 | 3 | 62 |
| Transferred | 11 | 4 | 6 | 1 | 1 | — | 1 | 24 |
| Special Circumstances | 4 | — | — | — | — | — | — | 4 |
| Died | — | — | 1 | — | — | — | — | 1 |

*Special circumstances.*—Four patients, not in the ordinary way suitable for Neurosis Centre treatment.

some form of individual therapy has been necessary. Our broad outlook on treatment is a psychotherapeutic one and an advantage of the organization at our disposal is that it has been possible in selected cases to give psychotherapeutic interviews several times a week and over substantial periods. In other cases weekly interviews have sufficed but many patients required physical remedies. ECT, minor insulin, sedation and drug therapies all have their place in such a unit as this: where major physical measures, such as deep insulin, have had to be undertaken, it has been necessary to transfer the patient elsewhere. Limited research schemes are possible and experiments have been carried out on the treatment of neurosis by acetylcholine and by methedrine (Maclay, 1953). We have one psychotherapeutic group consisting of women and one of men.

*Inter-personal Problems.* Difficulties in inter-personal relationships may involve staff or patients or both. In our first 2 years problems of this sort became so serious as to threaten the survival of the unit. Much time was spent in interviews before the psychiatrist could get an adequate understanding of what were the real factors operating, but in the end adjustments were effected that enabled us to sail on an even keel. The following are instances of the sort of difficulty that arose:

Senior nursing staff who worked together in the unit also shared the same small sitting room in the Nurses' Home, and strained relationships became a serious problem. At least 3 nurses were so neurotic as to be unable to cope with these tensions. They displayed overt symptoms and eventually left us to find work in a less stress-producing atmosphere.

A second variety of inter-personal stress involves patients *and* nurses. In a few instances a number of patients have combined in their complaint against a member of the staff for some real or imaginary mistake; the underlying cause may be something quite different, such as jealousy regarding the attention given to particular patients. These occurrences are usually marked by deep and devious undercurrents of feeling within the ward community; and a degree of inner insecurity may exist even among members of the trained nursing staff and may render these valuable assistants unable to bear ward stresses with equanimity.

*The Ward Meeting.* One way of dealing with this situation is that patients and staff should meet together as a group. It soon became apparent to both patients and staff in such a group that if the matter were pursued far, some of the more aggressive personalities would express recriminations against one or more of the more anxious or depressed, who were ill-equipped to bear such a load at that stage in their treatment and would probably suffer harm. There are limits to the applicability of the ward meeting among a mixed group of neurosis patients such as ours, and the present conclusion is that a group meeting of this sort cannot safely be carried to deeper levels of feeling, though it may serve a useful purpose in permitting the abreaction of specific discontents in a superficial way and promoting some improvement in inter-personal cooperation. It can usefully provide a forum for the discussion of matters affecting ward management etc. Complex reactions are more properly dealt with in the smaller therapeutic group or in individual sessions.

From time to time patients undergoing psychotherapy tell the psychiatrist details of inter-personal differences and hostilities; the writer's policy is freely to permit the recounting of such matters as they arise. In this way it is often possible to achieve release of a part of the patient's tensions and to assist him/her in the handling of his/her own difficulty; and sometimes the psychiatrist can, by direct but usually subtle adjustment elsewhere, ease the tension slightly—at the cost, nevertheless, of an appreciable strain upon himself. The stresses of interpersonal feeling proved to be both wide and deep and called for all the patience he was able to muster. Following are some examples of stresses between individuals:

An out-patient developed a close association with an in-patient, and became involved in a difficult decision whether she should take over the care of the in-patient's child. The in-patient favoured this arrangement but her husband objected and this involved the psychiatrist (who had also been recently consulted by the husband about a personal facet of the matrimonial problem) in the handling of this matter affecting these various people, while he was responsible for the treatment of two of them. This duty could not be evaded: the psychiatrist had to avoid making a decision for anyone, but it was not only a case of helping the various parties to clarify in their own minds the issue involved but also required that the contesting husband and wife should be brought to a point where they could agree to a compromise arrangement. In the end the out-patient did take over the care of the child by mutual consent.

A depressed patient signed an agreement letting her house to the husband of another patient, and when the second patient left hospital the couple moved into the house. The depressed patient would not have made this concession had she been in possession of her proper judgment and when the situation became clear to her there was much recrimination, arguments took place, and a solicitor was consulted; when she was ready to leave hospital there was still no home for her to go to. Here again the psychiatrist and the departmental sister had to play some part in the handling of an issue involving two of their patients.

It was discovered that the keys of the poison cupboard were missing, and suspicion fell on Mrs. A. About the same time Mrs. A accidentally walked into Mrs. B's bedroom, carrying a pillow. This trivial incident registered itself in Mrs. B's mind as unusual and unaccountable and, when she later heard of the loss of the keys, she felt that the facts might be connected; but her loyalty to Mrs. A did not allow her to communicate her suspicions to the sister. Some hours later the keys were mysteriously back in their place and for us that was the end of the matter; but not so with Mrs. B, who was unaccountably unhappy. The psychiatrist found time to give her a special interview that day and an important circumstance emerged: When Mrs. B was a child a fatal accident occurred which she believed had been more or less deliberately caused and that her parents were closely implicated. She knew it was her duty to tell someone about this, yet felt she could not, and as a result she had a sense of guilt. Now, once more, she felt she ought to have revealed the incident of the pillow but could not do so, and this re-activated the guilt felt over the earlier and far more serious matter. Discussion with the psychiatrist of what had thus been brought to light was a useful therapeutic measure.

*Occupational Therapy.* No department could have cooperated with us more generously than the O.T. unit has done; yet it is in connexion with O.T. more perhaps than anywhere else that we have been aware of the disadvantage of being a mere part of a hospital not otherwise designed for the treatment of neurosis. O.T. is essential in the treatment of neurosis, and the

drawback is that our O.T. department is ill equipped to cater for anything other than the making of soft goods and small articles. Many patients benefit more from O.T. that is of such a nature that they can fee they are actually helping in the work of the hospital or if it bears some relationship to the activity in which they would ordinarily be engaged. To some extent the occupational therapist has been able to provide this by improvization or by giving our patients opportunities of assisting her in organizing functions for more severely crippled patients from other sections of the hospital.

In trying to find other activities for our patients we have met certain obstacles. When we wished a patient to be employed in cutting grass in the grounds it was feared that he might be injured and claim damages. When we wished a patient to paint garden seats some issue was raised concerning trade union principles. Both proposals were eventually agreed to, but this has not always been our experience and many opportunities of work for the patients we have been unable to develop. The administrative authorities of a hospital tend to be apprehensive regarding the innovation of patients performing what might be regarded as normal work, outside the ward routine of cleaning, bed making, etc., but we find that, as instances of such work performed successfully come to light, the official side of the hospital can gradually be won over to our point of view. The function of liaison between the administrative personnel and the medical and nursing staff is a matter of no small importance and will repay time and trouble.

Another problem is that some patients are disinclined to work at O.T. The reasons are sometimes valid, as in the case of the patient with acute phobic symptoms, but sometimes it is due to what even a psychologist would call laziness, and in this matter we feel justified in using considerable persuasive pressure. The sister has established the custom that patients go to O.T. though exceptions may be made on medical grounds and this has been found to eliminate some of the difficulties.

*After-treatment.* Related to length of stay in hospital is the question of after-treatment. While, naturally, it is our hope to restore a majority of patients to a state of health stabilized sufficiently to enable them to carry on a normal existence without further help from us, there are others who continue to look to the centre as a fount of security. It would seem that this role is a section of the service that we ought to give to the community. We are not here considering those patients who continue to attend for psychotherapy but rather the group who, having left the hospital continue to feel dependence upon it. These patients are wont to come back at intervals in order to meet members of the staff and other patients. On one occasion former patients organized an evening reunion in the ward. The similarity to the idea of the day hospital springs to mind and we have the impression that, as we are able to add occupational and recreational facilities, this idea can be further developed to the advantage of some of our patients. As it is, a small number have become members of an out-patients' club run by a psychiatric social worker in a neighbouring area.

In the transition from hospital life to that of the world outside it is sometimes useful if a patient can start paid work while still having the advantage of residence in the ward, and a small number of patients have been assisted to rehabilitation in this way. In no case so far has it been found necessary to continue the arrangement beyond a few weeks.

*The Nursing Staff as Therapists.* A patient undergoing psychotherapy told the sister that she was afraid of her interviews with the psychiatrist because of the sexual relationship involved. Obviously this feeling needed to come out but the censorship in the therapeutic session was too strong. A small though definite amount of important material reaches the psychiatrist by this devious route and it is well to make use of this circumstance. In a further selected number of cases, where good rapport between a patient and a sister or staff nurse appeared to be developing, I have encouraged the latter to pursue the psychotherapeutic situation with the patient, thus taking over the actual treatment, allowing for periodic reference by the nurse to the doctor. This has sometimes allowed more therapy to be carried on than the psychiatrist has had time for; it has also widened the opportunities open to the senior staff of finding interest in the work of the ward, of achieving a better understanding of patients and their problems, and of gaining experience. But in a much wider sense than this the nursing staff, both trained and untrained, have constant opportunity to take an active part in social and individual therapy. Nurses are encouraged to play games with patients and associate freely and naturally, and there is something which has grown up in the social atmosphere of the ward kitchen, where little groups congregate at any hour of night or day and which appears to have a community value all its own. The night staff have been willing, where patients' needs seemed to call for it, to talk with them at any time; and this homely feature of hospital life is to be commended. Country dancing is a recent and promising innovation. On occasion, nurses—trained and untrained—have voluntarily given up their time to go out with patients on a shopping expedition or perhaps a visit to a neighbouring town.

*Rules.* In the early discussions between the psychiatrist and the sister-in-charge it was decided to commence operating the unit with one regulation alone—that patients were to tell sister or nurse if they wished to go outside beyond the immediate precincts of the ward—and to add further rules only if it was found to be necessary. A fire subsequently led to the introduction of a rule about smoking by patients who had received sedatives. It was decided that visitors should be asked to leave the ward by a certain hour in the evening and a fourth rule forbids the driving of a motor vehicle within 48 hours of taking a drug; but we have legislated on very little besides, trusting that patients will respond if we adopt in the hospital much the same attitudes as an innkeeper would in his hotel or we should towards visitors in our own homes. Only once has the writer felt some concern regarding a sexual relationship

between a couple of patients; but in this matter, also, a policy whose only aim was safety would be an unwarranted interference with liberty.

*Buildings and Supplies.* We have had a number of expressions of pleased surprise that the unit is so agreeable. A patient recently referred to the pleasantness of the building and its surroundings, to the comfortable mattresses, to the freedom patients enjoy and the absence of locked doors, to the liberty the sexes have of mixing with each other at will, and to the good food. It would be a mistake to disregard the advantage that accrues from a modern building standing by itself at a little distance from the other wards of the hospital, surrounded by grass and flowers and with a bright interior divided into public rooms and bedrooms that emphasize the element of personality rather than the barrack-room quality of the large ward.

As soon as our ward was opened for in-patients 3 years ago a difficulty presented itself with regard to the evening meal, which was inadequate for physically healthy patients in a neurosis centre. Friendly contact between our nursing staff and the hospital departments concerned overcame this difficulty immediately.

This experience of little more than 3 years leaves us with still a great deal to learn. In particular we should like to know more of how the inter-reactions between patients and between patients and staff may be used in furthering the treatment of neurosis. And we are still experimenting in the effort to discover the best way, within a small self-contained unit, to resolve those emotional stresses that spread from time to time within the little community and tend to involve everyone, staff and patients together.

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