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PSYCHIATRISTS AND NURSES: A SOCIOLOGICAL STUDY OF PSYCHIATRIC IDEOLOGIES AND PRACTICES IN AN INSTITUTIONAL SETTING

by

Alison May Harold

B. A. University of Stirling, 1975

A THESIS SUBMITTED IN PARTIAL FULFILLMENT

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Psychiatrists and Nurses: A Sociological Study of Psychiatric Ideologies and Practices in an Institutional Setting

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ABSTRACT

This thesis attempts to examine the various therapeutic ideologies subscribed to and put into practice by psychiatrists and nurses in their everyday work on the wards of Crease Clinic. The management and care of the mentally ill is recognised as problematic both by the psychiatric professions and by those concerned with examining the processes of definition and treatment. Psychiatry in the institutional setting, while it may subscribe to a dominant therapeutic ideology, is practiced in a situation of competing ideals, contradictory therapeutic roles, and practical everyday problems relating to the patients. This has also been observed in the psychiatric hospital by, among others, Stanton and Schwartz (1954), Strauss et al (1964), Rubenstein and Lasswell (1966), Scheff (1970) and Altschul (1972).

The essential problem relating to this, is the way in which the various interactants can carry out their work in a situation characterised by such ambivalence. This thesis also attempts to examine the effects of institutional

changes which occurred during the time of this study. It addresses the attitudes of the therapists to this change and questions whether this added to the problems already extant in the hospital.

This research in Crease Clinic covered the period from May 1976 to March 1977, and was based on participant observation of the everyday interaction on the wards, and open-ended interviews with 50 nurses and four psychiatrists.

I found that psychiatrists develop their ideas about psychiatry on the basis of their training, through personal experience, and by adaptation to particular ward situations. Nurses were apparently more influenced by their work experience in dealing with the day to day ward problems, although there seemed to be some difference among the nurses, in psychiatric ideology subscription, on the basis of sex. The sometimes contradictory views between the psychiatrists and nurses were found only occasionally to result in confrontation. Potential conflict was generally channelled by the nurses, who simultaneously succeeded in enhancing their status position relative to the psychiatrists. The reorganisation of the Clinic also contributed to this situation of uncertainty, adversely affecting the nurses' attitudes to the hospital administration, and contributing to job dissatisfaction. These problems were

partly based on the increasingly 'chronic' nature of the patients being admitted to the hospital. Lack of communication and doubt relating to the future, resulted in general anxiety for the majority of the nurses. As a result of these factors, the psychiatrists and nurses working in Crease Clinic, facing this variety of problems, adopted an eclectic, sometimes ambivalent approach, to the treatment and care of patients.

For my parents

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I wish to thank Professor Robert Wyllie for his continual support and invaluable guidance as the supervisor of my work on this thesis, and Professor John Whitworth who also commented and advised on its content and structure. I am totally indebted to them both.

I am also indebted to Dr. Ed Lipinski, both for his information concerning psychiatry and for initially contacting Riverview Hospital, thus facilitating the research.

Within Riverview Hospital itself, my particular thanks must go to Ian Manning, the Executive Director, for all his help and information; to Dr. McFarlane who gave me permission to conduct the field work, and to all the staff of Crease Clinic who gave me their time and co-operation.

Finally, I would like to thank Lorna Estridge, for patiently typing the final draft.

The responsibility for the completed product lies entirely and inevitably in my own hands.

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INTRODUCTION

The Subject

This thesis constitutes a study of the psychiatric ideologies and practices in Crease Clinic, one Unit in Riverview Hospital in British Columbia. While Riverview Hospital (formerly entitled Essondale) has been in existence in its present locality since 1913, Crease Clinic was not established until 1951. It was constituted by a proclamation of the Clinics of Psychological Medicine Act, partly in recognition of the need for a facility in the area for the treatment of acutely ill patients, as opposed to the more custodial care given to patients in the other Units at Riverview. The "Crease Clinic of Psychological Medicine" was established to provide;

> . . . complete diagnostic and treatment facilities for the early cases of mental illness. To enable this, the new Clinic Act provides for admissions by voluntary application or by medical certification of two physicians without any further legal documents. A period of four months is the maximum period of time any patient may remain in the Clinic; thus any diagnosis and treatment must be carried out in a comparatively short period of time. 1

The official purpose underlying Crease Clinic has not changed much over the years, although the maximum time for stay has been abandoned. The aim of this thesis is to examine psychiatry as it is actually put into practice in this Clinic.

People who work in psychiatric hospitals are involved in large complex institutional structures, officially aimed at the treatment and care of the mentally ill. While such institutions have particular goals and have been designed for particular purposes, the people who work in them may not share these same perspectives. Indeed, employees may not share a consensus of this matter. The problem is further complicated when we consider the diversity of individual

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1. This information was taken from a report, by the Clinical Director on the developments of Crease Clinic in its first few months of existence, in the Mental Health Services Report, 1950-1951:023.

perspectives relating to treatment and care. The major aim of this thesis is to elucidate the ways in which psychiatrists and nurses define their work and objectives and how they put them into practice in Crease Clinic.

This thesis initially examines the structure of Crease Clinic, the daily ward activities and the functions of the various therapists employed within the institution. It also discusses a conference held at the Hospital to examine the future role of Riverview.

This conference reflects the awareness that the care of the mentally ill is increasingly being taken over by community facilities and by the psychiatric wards in general hospitals. Anyone suffering from a short term 'acute' illness is treated in those areas. Hospitals like Riverview are now receiving only patients who have long term 'chronic' illnesses. As Crease Clinic was originally established as a facility for short term patients, the nursing staff are oriented to the type of treatment associated with this.

A major part of the thesis is concerned with psychiatric ideologies and the ways in which these are put into practice. The discipline of psychiatry has its roots in various traditions and these are reflected in theory and practice today. Various therapists subscribe to different psychiatric ideologies and these theories are exercised in the treatment of patients. Within the institutional context the major perspectives extant in present day psychiatry

are based on organic approaches to aetiology, diagnosis and treatment, on psychotherapeutic approaches, and on perspectives which concern themselves predominantly with family and other environmental factors. The last two overlap to a certain extent.

Psychiatrists working in Crease in common with those in all other large mental institutions, are more concerned with diagnosis and treatment than with aetiology. Time limitations in particular present problems for any in-depth analysis of the causes leading to a particular mental illness. This as we might expect, poses a problem for the psychiatrists.

The particular types of therapies utilised by the psychiatrists in Crease are also examined. Chemotherapy - the major tranquilisers, anti-depressants and Lithium are generally given to most institutionalised patients and Crease was no different in this respect. In addition to this form of therapy, psychiatrists frequently subscribe to other approaches to treatment. They emphasise to a greater or lesser degree, the use of psychotherapy. This usage may not be identical to the techniques described in the psychiatric textbooks, but more likely has been developed and changed through practical experience to conform to the everyday problems in dealing with the patients. Similarly psychiatrists also use their knowledge of the patients's familial and general environmental background, both in diagnosis and as part of the treatment programme. The

problem to be considered here then is the ways in which the various psychiatrists in Crease put into practice what are confusing and eclectic approaches to therapy.

Nurses are in contact with the patients on a more regular basis than are the psychiatrists, and this means that their views merit serious attention when we consider psychiatry as it is practiced. Nurses, unlike psychiatrists, are more inclined to form their role conceptions and act in the performance of their work on the basis of extensive contact with the patients. The problems which will be considered here are how the nurses perceive the wards they work on; how they define their roles; how they act in the performance of their everyday duties, and how they perceive the patients. A related problem which will also be examined is the importance of certain variables such as past and present experience, location of training, age and sex,in the formation of the nurses' attitudes.

In their training, nurses and psychiatrists are taught similar approaches to the discipline of psychiatry, and to treatment and care. Several problems relating to this matter are investigated. Firstly, nurses subscribe to a similar wide variety of therapeutic techniques and ideologies but they deal with the same patients. Therefore one patient may find himself being treated by a number of persons subscribing to different perspectives. Secondly,

nurses are expected to act in accordance with the orders of the nursing supervisors and with their written job descriptions, with the ideas of charge nurses who may define the therapeutic situation on the wards, and with the orders of the psychiatrists who are in ultimate command over the treatment and care of the patients. This can lead to a confusing therapeutic situation on the wards, one which is laden with potential conflict and where job dissatisfaction is likely. Thirdly, since both nurses and psychiatrists are trained to deal in psychotherapy with patients, it seems likely that some confusion may arise over whose job this is.

Given these ambiguities and difficulties, it is important to examine the manner in which the various therapists carry out their daily duties and how they manage to retain a sense of optimism in dealing with the treatment and care of patients.

One further problem is addressed throughout the thesis. With Riverview Hospital in a state of transition, increasingly only admitting the more chronic patients, attitudes of the personnel to this matter are important. Institutional change always results in a certain degree of disruption and adverse feeling to the institution. The perceptions of the nursing staff to both the implementation of these changes and to the changing nature of the patients are crucial to

an understanding of the institution's functioning.

Generally this study contributes to an understanding of the functioning of organisations. Etzioni (1964:3) defines organisations as;

> social units (or human groupings) deliberately constructed and reconstructed to seek specific goals.

Organisations are characterised by a division labour, communication responsibilities, by one or more power units which control the organisations' efforts all of which are planned to realise the organisations' goals. Personnel are also substitutable, transferable and promotable.[2] These are all factors which are investigated in this thesis relative to Crease Clinic.

The sociology of occupations is closely related to the study of organisations. Hughes (1964:25) argues that the central concerns of a sociology of occupations are;

> to what extent do persons of a given occupation "live together", and develop a culture which has its subjective aspect

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2. Etzioini (1964:3) argues that organisations like hospitals cannot rightly be termed bureaucracies, because they are characterised by several decision making centres.

> in their personality? Do persons find an area for the satisfaction of their wishes in the associations which they have with their colleagues, competitors, and fellow-servants? To whose opinion is one sensitive?

In this thesis we are considering people, that is psychiatrists and nurses at work, from both a social-psychological and an organisational perspective. By examining their problems, in defining their roles, in carrying out their everyday work, in co-operating with co-workers and in job satisfaction, we are not stating that these are problems faced only by nurses and psychiatrists.

The primary contribution of this thesis is to the sociology of medicine, and in particular to the sociology of psychiatric institutions. An important consideration here is the examination of the process of change in a psychiatric hospital. Most of the literature which discusses reorganisation in psychiatric hospitals examines a process which involves a movement from custodial care to psychodynamic, humanistic treatment. This process introduces open wards, democratic sharing of responsibilities by the staff and by the patients, and intensive psychotherapy. Riverview, on the other hand as a result of its redefinition as a secondary referral area, was moving in the other direction - back to locked wards and to an emphasis on 'asylum' for certain types of patients. This

is a phenomenon which will likely affect a number of state hospitals in North America, as treatment of the mentally ill is increasingly dealt with in community facilities.

The Method

The study of Crease Clinic (and the everyday activities therein) was begun in May 1976. Most of the field research was done during the months of May to September, and December 1976 to January 1977. During this period I spent around eight hours in the Clinic on most days. During intervening months and from January to March 1977, I spent one or two days a week there. I passed most of the day with the nurses in their daily routine, attending meetings, ward rounds, discussions and participating in the numerous daily activities. With the permission of the Hospital Medical Director I made my purpose known on the wards. I made no attempt to hide or distort the reasons for my being there. My introductory period in the Clinic was facilitated by the Medical Director who introduced me and my interests to the nursing supervisors and to the charge nurses of each ward.

When I first arrived on the wards reactions varied among the different nursing staff. On being introduced on West 3 (one of the wards in the Clinic) to the charge nurse, he commented on how paranoid the staff became when

they were being observed; "people are always studying us they check to see how we earn our money". Similarly the charge nurse on East 2, immediately wanted reassurance that no names were to be mentioned. In general, after two or three weeks I was always made welcome on the wards, and the nurses and psychiatrists seemed quite pleased at my being there.

In gathering the qualitative data I employed two styles of methodology. The first involved a 'participant observer' approach. I listened to conversations, asked questions, and generally noted attitudes, ideas and practices. I spent the working day on the wards observing, discussing and generally passing the time of day with the staff. I occasionally asked questions as topics arose in the conversation. After a few weeks the staff required very little encouragement to talk and were usually willing to give extensive opinions on matters concerning the hospital.

I carried my notebook with me constantly, and recorded situations as they were occurring. When I felt that this would intrude upon the staff or the patients, I waited until no one was around, and sat in the nursing office writing up my recollections. The time span between such situations and the writing was very short - probably at most 20 minutes.

At ward rounds and other meetings I could always write as events occured, mainly because everyone else present was making notes.

I also made use of unstructured interviewing methods, after waiting for three weeks in order to gain the confidence and the co-operation of the staff. I took a random sample of nurses on each ward, which totalled 50 respondants. [3] Included in these 50 were all the charge nurses, because of their central importance on the wards. Over and above this I interviewed the four psychiatrists who were in the unit for the entire year.

As subjects came up in conversation I demonstrated special interest or posed questions. I was careful to couch such questions in terms of; "What do you think about, . . .?", and not in judgemental terms as in; "Don't you think that . . .?". These conversations were written in my notebook during the interview or were recorded on tape, depending on the preference of the informant. Before each interview I asked each staff member which method they

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3. For full details of the nurses, the wards they were employed in at the time of each interview, their sexual status, whether they were trained in Britain or North America, their experience in psychiatry, whether they were trained as psychiatric nurses, registered (general) nurses, or both see Appendix A. The past experience of the Operating Room staff is given in terms of years in that area, and not in psychiatric nursing. This was because I was concerned with their attitudes to the changes in the hospital and not with their opinions relating to psychiatric treatment and care, which was not part of their work in that area anyway.

would prefer. The interviews with all the psychiatrists were taped. These interviews with the staff ranged in length from 15 to 60 minutes.

In analysing the data from the interviews I categorised statements as they related to the subjects for consideration in the thesis. These problems were as follows:

a) How do they define their roles?

b) What do they see as the "ward" (or official) definition of the therapeutic situation? Do they agree with it?

c) Do they agree with the work done by the other nurses on the ward?

d) What is their orientation to treatment and/or what therapeutic approach do they disagree with?

e) Who do they think should be involved with psychotherapy? Is this the work of the psychiatrists or the nurses?

f) What are their attitudes towards the administration and the institution in general?

g) Where did they train and what are their qualifications?

There are numerous problems associated with the participant observer approach. First, for the recorder of events,

there is the problem of maintaining the confidence of the people under investigation, and this includes the problem of maintaining observer neutrality. This practical problem can be circumvented reasonably easily by not making any judgements relating to the staff's comments, and by not making any statements which could be conceived of as controversial.

Another problem is the possibility that the 'subjects' exert some sort of influence thus altering the observer's perceptions. This is always possible in a situation where it is necessary to gain rapport with a group of people over a long period of time. This can be counteracted by simply removing oneself from the environment, constantly reviewing the data obtained to date and reviewing other literature related to similar institutions. This would be much more of a problem if the observer were actually living permanently in the environment being studied. As Sjoberg and Nett (1968:176) propose;

> . . . there are liabilities to any effort to maximise one's immersion in a system. Aside from the danger of losing one's identity as a scientist, the researcher may become the captive of the group he is studying.

There is also the likelihood that the presence of the observer will influence the responses of the subjects.

While there is no way of actually preventing this process, it can be counteracted if the observer presents himself in a non-threatening way and makes explicit to the respondants, in this situation anyway, that he is not in league with the administration, and not making any judgements. It would seem unlikely that the nurses and psychiatrists in their daily activities over the period of a year, could constantly act in ways different from their normal behaviour. The data obtained from the interviews can be assumed to contain reasonably honest responses. In general, the nurses and psychiatrists responded immediately to questions, answered more than they were asked and said certain things which would imply that their beliefs and actions were commonly known in the ward situation. Moreover, they did not hesitate to state their opinions in strongly emotive terms.

The method also limits the study to being a description and analysis of a particular setting at a particular time. While the method is replicable, verifiability of the findings is problematic. Other literature on similar institutions however, indicates that the type of information obtained is fairly common and accurate.

There are numerous and important advantages of using this method in this situation. By being present over a long period of time I came to understand the situation which was involved in the running of the wards, the general

work styles of the staff, and the frustrations and problems arising in day to day hospital life. As Lofland (1971:6) maintains, "the bedrock of human understanding is face to face contact". By participating in this everyday life it was possible to note the ideals, definitions and understandings of the staff and to report the variety of opinions in their own words.

Other methods such as using questionnaires and quantitative data could of course be used in this situation, but I believe they would not have brought to light such extensive and detailed results. Unstructured interviews can illuminate numerous points of interest and valuable information which would not ordinarily be tapped by structured questionnaires built on preconceived ideas. Moreover such a method would obviously fail to study the everyday interaction processes on the wards and this was one of the main concerns of this thesis.

There is always an ethical problem involved in doing such research, particularly when it is carried out in a psychiatric hospital. However I did confirm in writing to the Medical Director that no patient names and related information would be used. The staff were also aware of what I was doing - this was made explicit to them by the charge nurses and was re-emphasised by me. In addition I changed the names of all the personnel mentioned or quoted

in the writing of the thesis.

There are several concepts utilised in this thesis which require definition. A central concern of the thesis is what I have termed "psychiatric ideologies", or "ideological orientations". These are shared sets of beliefs concerning the aetiology, diagnosis and treatment of mental illness. They are considered in relation to other sets of beliefs - ideologies held by other psychiatrists and nurses. So we are considering one psychiatric ideology for example - 'the organic', versus another psychiatric ideology - the 'psychotherapeutic', and the people who subscribe to these belief systems. A similar perspective was adopted by Strauss et al (1964), in their study of psychiatric hospitals.

The concept of "role" is one which is often confused in usage, both in Symbolic Interaction theory and in everyday language. Its meaning is often confused with that of "status". While "role" is certainly part of "status", it is much more. As Turner (1962:23) argues:

> The idea of role taking shifts emphasis away from the simple enacting of a prescribed role to devising a performance on the basis of an imputed other role.

The psychiatrists, and more particularly, the nurses, based their roles on their own conception of their work and on the

written 'official' description of their work.

> . . . role behaviour in formal organisations becomes a working compromise between the formalised role prescriptions and the more flexible operation of the role taking process. (Turner, 1962:38)

So role definition and role performance, as used in this thesis, are based on the above definition. It is this process which is also one of my central concerns.

"Conflict" is another concept frequently employed in the thesis. Its usage here is very broad and does not imply that the basic perspective of this thesis is conflict theory. It is used when discussing opposing ideas or practices, competition and contradiction, but not necessarily confrontation or power struggles.

Review of the Relevant Literature

As a result of the changing perspectives on the treatment and care of the mentally ill over the past 25 years, and because of the growing recognition of mental illness as a crucial social problem, there is a large body of sociological and psychological literature which examines psychiatric hospitals from a variety of perspectives. Because of its extent it would be impossible to cover all of this literature at this point. There is a multitude of

books and articles written on the subject, not to mention the equally vast number of documents which discuss mental illness more generally, or that which examines the care of patients outside the psychiatric hospital.

The appearance of sociological studies of mental health and of the sociology of medicine in general, is an indication of this growing interest. These studies take the form of histories of health care, analyses of medicine as it is practiced in society now, not to mention criticisms of medicine, or more particularly psychiatry.

In the first category, the most encompassing work is that of Alexander and Selesnick (1966). They analyse the development of psychiatry from early civilisations to the present time, tracing certain similarities in thought through various time periods. The three basic trends in psychiatry, as they define them, are the organic, the psychological and the magical. The rise and fall of these psychiatric perspectives are analysed in relation to dominant societal thought in each period. Psychiatry as it exists today is seen as a reflection of its historical development. Similarly, Foucault (1956) considers the development from the Middle Ages to the 18th century. He concentrates more on societal perceptions of the meaning of madness and the role of the madman in society. These historical studies are the bases for the structure of modern psychiatry as

considered in this thesis. Although they pose no particular problems for examination, they do place psychiatry and its practice in a particular perspective which illuminates present day thought and practice.

The general studies of mental illness in society are vast in number and are directed at a multitude of topics. Mechanic (1968), for example considers the sociology of medicine in general, but his work is important for our perspective in particular, in his analysis of the organic approach to psychiatry and his discussion of the doctor-patient interaction situation. Mechanic emphasises the point so frequently made in the literature on traditional healing practices, that the suggestive power of the therapist is one of the major influences in his therapeutic effectiveness.

Freidson's (1970) book is similarly important. Although his analysis is broadly concerned with the theory and practice of medicine, he also emphasises the interaction between the psychiatrist and the patient. In this case, the emphasis is on the psychiatrist's faith in his healing powers, and his reliance on affiliation with other like minded psychiatrists.

Frank (1971a) examines this situation in great detail. The general argument of this book concerns itself with the

element of faith in the psychiatric treatment situation. The psychiatrists' training and experience forms the basis for their confidence in their capacity as healers.

All of these works are important in examining the perspectives of the psychiatrists. In analysing the statements and practices of these psychiatrists, these previous studies form the basis for considering certain problems relating to psychiatry as it is practiced.

Clare's (1976) recent work analyses almost every aspect of psychiatry. Subtitled, Controversial Issues in Thought and Practice, it examines just that subject. Clare considers all approaches to the aetiology, diagnosis and treatment of mental illness in great detail. Using the results from various sociological, psychological, psychiatric and medical studies, he takes each controversial issue, (and he assumes that every aspect of psychiatry today is controversial) and considers confirmatory and contradictory evidence for the various perspectives. Included in this is an analysis of the problem of what constitutes mental illness, and in particular, what is schizophrenia. He uses cross-cultural studies in support of his approach. While Clare advances no particular theoretical argument, his book is one of the most encompassing critical analyses of a discipline - psychiatry - which has come under attack in recent years. He places in perspective most other com-

parative studies and considers how they fit into the overall theory and practice of psychiatry.

One of the most important thinkers on the subject of mental illness is Scheff. (cf. 1960, 1962, 1966, 1968, 1970) From his Ph.D. thesis (1960) which was concerned with nurses' attitudes to institutional change, he developed his analysis to encompass the subject of mental illness more generally. In his book Being Mentally Ill, (1966), he discusses the various processes involved in a person becoming ill, and the role that he is forced to enact in this capacity. He considers the process from the point at which some type of deviance is initially labelled as symptomatic of mental illness, through to the diagnostic process. He is particularly concerned with the reaction of the audience to the person being so defined, and the processes involved in that person adopting that role. The self concept of the actor is the crucial dependent variable in this situation, and he will adopt the role (of being mentally ill) if he is defined as such, particularly by important others.

Psychiatry has also come under attack in recent years not only by sociologists but also by psychiatrists themselves. For example Szasz (1961) raises the question, "is there such a thing as mental illness?", and argues that there is not. While he admits that there are certain organic

illnesses, he considers these to be diseases of the brain and not of the mind. He is concerned mainly to debunk the myth which he considers has developed since the time of Charcot and his analysis of hysteria. "Mental illness" Szasz argues has outlived its usefulness. People are now inclined to consider that all problems of life are psychiatric problems for the behavioural sciences to solve.

Torrey (1974) adopts a somewhat similar perspective. The medical model as an analysis of human behaviour, he maintains, is no longer useful; problems of behaviour are not 'diseases'. He proposes that psychiatry must die because it does not fulfil the needs of the members of society.

Even when we narrow the subject area down to the study of psychiatric hospitals, we find a huge number of relevant works. Nevertheless it is necessary at this point to examine a few of the major works which discuss mental institutions, and which pose some problems for consideration in this thesis.

Stanton and Schwartz (1954) conducted a joint socio-psychiatric study of a hospital organisation and some therapeutic changes as they were implemented in particular situations, and the impact of these changes on the staff members and the patients. They commenced with the basic

assumption that all institutional goals are to some extent shared, but that these are pursued by a complex division of labour within the hospital organisation. Within this organisation they also assumed that there must be methods for both maintaining stability and for introducing changes. Essentially this argument is that such an institution can only exist if it largely meets the needs of those people in it. They found that the hospital was successful in achieving its official purposes that is protecting the public and meeting the minimal needs of the patients, but less so in actually improving the patients' illnesses. This was partly a result of a high staff turnover, which left the patients in the hands of inexperienced staff. Another major problem lay in the inadequacies of the organisation and decision making in the hospital. This subject, they found, was rarely discussed.

Caudill (1958) approaches the problem from the perspective of patient life on the wards and patient and staff perspectives of the hospital. Caudill's study is a day to day analysis of life in the psychiatric hospital as a small society, and an attempt to understand the therapeutic situation therein. This hospital was in a state of transition and was facing certain problems related to this.

Caudill's study however is directed toward much broader concerns. He considers a) daily events at the various levels of the hospital and how these were interrelated, b) interviews with members of all role groups in order to determine the patterns of perceptions of the hospital, and c) daily conferences, which included doctors, residents, nurses, social workers, and occupational therapists, and the interaction and communication flow between these various role groups.

Caudill was concerned to emphasise throughout his book that the hospital is an entire social system - a small society. Particular problems he discovered were differing perceptions of communication within the hospital - differing communications which, he speculates, would likely result in disagreements between several staff members concerning the treatment of patients. Different staff combinations seemed to produce different effects in diagnostic or social groupings of patients. He also found that there was a discrepancy between optimism expressed in interviews and frequent difficulties and frustrations encountered in the everyday work in the hospital. Job dissatisfaction was another problem which he found to be prevalent. In general, Caudill considers that psychiatric hospitals share many of the same problems as any hierarchically structured work organisation.

Scheff's (1960) Ph.D. thesis examines the problems which are central to most of the literature, although he did concentrate on the nursing staff. His main concern in the hospital he studied was staff resistance to change. This hospital was undergoing administrative change involving an attempt to abandon a custodial approach to patient care. He looked at the parts played by personality and the social structure, within the hospital, in generating resistance to such change. He analysed the various techniques utilised by the staff in this process of resistance, categorising nursing staff by their attitudes and personalities, and considering the importance of these factors to the particular responses to change.

The same problems are repeatedly emphasised in the literature on psychiatric institutions. Schwartz and Schwartz (1964) discuss the same process, although their main concern is with effective patient treatment and care. They emphasise the need for flexibility in the organisation, planned approaches to treatment and particular focus on the patients' needs. The basic solution for all this, they maintain, lies in the final analysis, in the social system of the hospital and effective management for therapeutic ends.

Rubenstein and Lasswell (1966) consider the decision making and the sharing of responsibility in the psychiatric

hospital, focusing on the problem of the reconciliation of organisation and goals, and the implications of this for policy making. These were related to the change of a hospital from custodial care, where patients were meant to be compliant and obedient, to dynamic particularly democratic treatment. While this is an emphasis in many of the studies of psychiatric hospitals, this book covers the problem and analyses it particularly well.

Rubenstein and Lasswell found that these innovations as they were implemented, resulted in certain problems, especially in so far as they pertained to power sharing and decision making. For example, patients joined with the staff in meetings, where they were expected, along with the staff, to discuss any topic of common interest. The innovations did not disrupt any formal psychotherapeutic interaction between doctor and patient, but they were more readily implemented because the traditional mode of treatment in this hospital had emphasised individual psychotherapy in the treatment of psychoses. The intitial movement to innovate in this particular case commenced in the late 1950's, after interest had developed in Maxwell Jones' (1953) experiments with the "therapeutic community".

Rubenstein and Lasswell found that with these changes power and decision making were more effectively shared than they had been previously, but that elements of the

traditional authority structure still remained; in the last resort decisions were made by the staff, and in particular, by the Hospital Director. Decisions were still made arbitrarily by the doctors who occasionally vetoed decisions arrived at by the other staff members. After the innovations, even those doctors who had worked in no other system, still sought to retain their power.

The nurses were in a particularly ambivalent position in this situation, as were the social workers, who were uncertain how to use their skills effectively. The patients too, did not seek any further power sharing, partly as Rubenstein and Lasswell argue, because they were accustomed to being 'losers' - being passive and dominated.

Rubenstein and Lasswell concluded by analysing the problem of the ways in which genuine power sharing could have been possible in the hospital. For example, they recommended that certain committees could have been established with the ability to finalise decisions. These committees consisting of all staff and patients would have decided on patient goals and abided by them. It seemed in the last resort, that the problem was more difficult to implement than had originally been thought, and that nothing less than complete political change within the organisation would have effectively brought about demo-

cratic decision making.

Other studies of psychiatric hospitals have reinvestigated this problem. Schulman (1969) similarly studied the introduction of therapeutic innovation and its impact on organisational effectiveness. Greenblatt et al (1971) found similar processes, and again concluded that resistance on the part of staff to change is based in the general insecurities which change inevitably produces.

Psychiatric ideologies and their practice were examined by Strauss et al (1964) in two hospital settings. The basic problem was the ways in which the various personnel, who embodied various perspectives and pursued different careers, managed to work together organisationally. In the state hospital they stressed the importance of negotiation between the various incumbents in the hospital division of labour, in the day to day treatment situation. This involved genuine discussion and bargaining, resulting in temporary agreements. A large part of this negotiation concerned types of treatment and the roles of the individual team members on an ideological level, but paid little attention to daily work. In the research hospital the opposite situation was found. Negotiation did not centre around treatment ideologies and the division of labour, but there was more involvement in

negotiating daily tasks.

Strauss et al conclude from this that organisational theory needs considerable modification to be meaningful for the examination of hospitals. Sets of norms or expectations are basically inadequate to explain the ward activity. The status of the various personnel presents problems to be solved through negotiation and interaction. This negotiation does not arise from conflict, from non-adherence to norms or the breakdown of expectations and understandings.

The literature discussed above sets the scene for the main body of this thesis and presents various problems which will be investigated throughout.

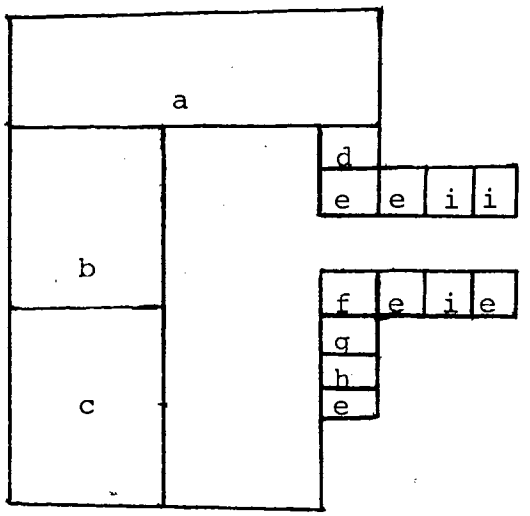
CHAPTER II

THE SETTING: CREASE CLINIC

The Wards

The first part of this section is necessarily descriptive and may inevitably be tedious. It is however important as background information to the main body of the thesis.

When I commenced the research in May 1976, Crease Unit consisted of six functioning wards, one unused ward and one operating room, with 193 available beds altogether. Apart from the wards, the unit also contained areas for Recreational Therapy, Occupational Therapy, Chaplaincy, laboratories, a beauty parlour, conference rooms and Social Services. There were offices for administrative and personnel staff, nursing directors and supervisors, and for the Riverview Medical and Executive Directors. On the ground floor was situated a library for the patients, a staff library and reference area.



Legend

a - day room
b - female dormitory
c - male dormitory
d - nursing office
e - office
f - kitchen
g - staff room
h - surgery
i - seculsion

Figure 1. WARD FLOOR PLAN

Three wards were situated on each side of the building, the East and the West wings respectively. Each ward was nearly identical in construction and layout, containing large separate dormitories for males and females, a dining area and a large day room all with barred windows. The nurses' office was situated next to the day room with a large window between which enabled the nurses to observe the patients' activities in the day room. Each ward also contained two or three offices (usually used by the psychiatrists or the charge nurses) a kitchen for making snacks, and a small staff room adjoining where the staff took their coffee breaks. On each ward there was a 'surgery' where the patients gathered at certain times to be given their

medication. A side corridor on these wards contained three or four seclusion rooms, empty apart from a mattress on the floor, with a circular glass window which enabled the staff to observe the patients in seclusion. The day room contained a number of arm chairs placed along the walls or arranged in small circles suitable for conversation, or around small card tables, and in one corner was a television mounted high on the wall which could be watched from any part of the room. The side corridor in West 4, when I commenced the research, was separate and locked as the Intensive Care Unit. The only other wards which were locked at this time were East 2 and West 2.

East 2 housed organic brain syndrome patients, 22 male and 15 female, ranging in age from 30 to 72, with the majority in the 40 to 50 year range. This was the only long stay ward in Crease. The patients had specific identifiable brain syndromes, largely resulting from alcohol use or automobile accidents and a few from syphilis. For the most part this ward can be considered separate from the functioning of the other wards in the unit with the exception of the surgical ward and the Operating Room.

The operating room dealt with general surgery for all Riverview and Valleyview patients, unusual surgery being referred to general hospitals in the locality. Eletroconvulsive Therapy was also conducted in the Operating Room.

West 2 contained post surgery patients on a temporary basis, who were transferred back to their original wards on their recovery. At that time West 2 contained 5 male and 6 female patients.

East 4 was an 'open admitting' ward with 19 male and 13 female patients, West 3 was 'open intermediate', containing 18 males and 6 females and West 4 was 'open continued care', with 12 males and 6 females. The patients in all these wards were considered acute, short stay, with a variety of diagnoses ranging from personality disorder to schizophrenic. The average stay in these wards was six to eight weeks. Several patients had been in much longer, some up to five months, and a high percentage had been in the hospital before, and had been discharged, only to be readmitted. This 'revolving door' phenomenon, as will be discussed later, is seen as a problem, not only in this hospital but in psychiatry in general. (see Appendix B)

Patients in the acute wards were generally allowed to move around the hospital and the grounds, attending various activities in the hospital. Not all however, were allowed this privilege. There were certain patients who remained on the wards and who were confined to wearing pyjamas. West 3 had written details and instructions which were given to all new patients and staff members. These instructions defined those patients in pyjamas as being

on "Level 1 " which included all new admissions to the ward, for a minimum period of 48 hours. Also included in this group were patients who had in some way broken the rules, such as making an escape attempt, or quarrelling with a nurse or a patient. In fact anyone seen as a 'troublemaker' or who showed no interest in co-operating with the therapeutic staff and with the treatment programmes, was generally confined to the ward in pyjamas and dressing gown and had to take their meals there.

Other patients from "Level 2" up, were permitted at least to eat in the patient dining room, accompanied by staff members. "Levels 2" to "6" were allowed various privileges and were required by the staff to meet certain standards. These requirements included attending meetings, discussing their reasons for being in the hospital, interacting in Occupational and Recreational Therapy, and taking care of the bed making and personal appearance. Any patient not fulfilling these requirements, as defined by the nursing staff, could be demoted to "Level 1 " to pyjamas, until they indicated and gave evidence that they would co-operate. "Level 3" included "grounds privileges " if that patient was accompanied by another on a higher "Level". "Level 4" granted unrestricted grounds privileges, and occasional week-end passes. The next "Level" permitted passes for outings with friends and relatives. By

"Level 6" the patients were expected to be considering their future, by arranging employment and accommodation, prior arrangements with the staff having been made each day. All of the acute wards classified patients along similar lines and had similar expectations. (see Appendix C).

Within West 4 was a separate locked Intensive Care Unit, housing three male and four female patients, classified as being "acutely ill, disturbed, high risk suicide or escape". A patient remained in this restricted environment until such time as it was considered that he had settled and could be contained in an open setting, the typical length of stay being two weeks. A psychiatrist described such a patient in this way.

> A 51 year old lady is admitted to the Health Services Centre Hospital . . . . A few weeks after her admission she seeks and obtains week-end leave . . . When her husband insists that she return to the hospital, she proceeds to drink rat poison . . . She is taken to the Intensive Care Unit of the Vancouver General Hospital. From there she's transferred to a medical ward and promptly jumps out of the window, sustaining multiple injuries. Frantic phone calls are made to Riverview and the patient is admitted to our Intensive Care Unit, a small locked ward with a high staff-patient ratio. She is better now, and has been moved to an open setting.

By March of 1977 West 2 surgical had been moved to another part of the hospital and the work load of the operating room was reduced. The remaining wards in Crease with the exception of East 2, organic brain syndrome, had been restructured and moved within the building. West 4 in September 1976 became a locked unit for most admissions and for disturbed, high risk patients. The Intensive Care Unit had become integrated, no longer existing as a separate ward within West 4. West 4 patients, on reaching a stage where it was no longer considered necessary to contain them in a locked setting were transferred to West 3. The average stay in West 3 remained six to eight weeks, after which the patients would generally be discharged to boarding homes, intermediate care homes, or sometimes to their own homes. Occasionally a patient was transferred to another building in the hospital, to a chronic ward. By March of 1977 there were 24 male and 17 female patients in East 2, West 3 housed 20 males and 20 females and West 4 contained 20 males and 10 females.

Originally Crease took admissions from the Vancouver area and Centre Lawn dealt with admissions from the rest of British Columbia. In June of 1977, two wards from Centre Lawn moved to Crease, and an 'extended care' ward in West 2 was opened in August 1977. Crease then dealt with

all admissions to the hospital. East 2 eventually moved to another building in the hospital at the beginning of 1978, thus making Crease entirely an acute unit.

The type of treatment practiced on each ward was largely determined by the official title of the ward and the types of patients housed therein. On the basis of this each ward was recognised by the administrators, and by the nursing supervisors, as having a particular function. As will be discussed in Chapters IV and V those therapists working on the wards did not necessarily agree with the 'official definition' of either the ward orientation, or of their particular roles and responsibilities, given their specific personal orientations and given the practical difficulties encountered in their everyday work with the patients. Psychiatric treatment as practiced in the large institutional context bears very little resemblance to textbook psychiatric theory.

The official definitions of the acute wards centred around the concept of rehabilitation and remotivation. Officially therapy was meant to be geared to diagnosing the patients illnesses, isolating particular social or psychological problems through in depth discussion, analysis and socialising the patients into acceptable ways of thinking and behaving, and finally discharge into the community. It was in these wards however where the

greatest variety of role definitions, of psychiatric ideology subscription, and even of therapeutic techniques, was to be found. In essence, it was there that most of the confusion and conflict was to be found. This will be discussed at length in later chapters.

These rather loose official definitions and expectations were reformulated in the practical ward situation by the charge nurses. It was expected by the nursing supervisors that the charges would, within the above confines, formulate particular ward philosophies, suitable to their ward situation and to their goals. As a nursing clinician stated:

> Some of them have ward philosophies, they are developed from ideas from the charge nurses with input from the staff and I try to discuss these with the staff and consider the problems. We try and believe in them and put them into practice.

The official definition of East 2 - organic brain syndrome - centred around 'functional' nursing, that is taking care of the basic physical problems of the patients. This definition and the resultant type of patient care had to a certain extent been determined by the head nurse who had worked in similar wards for nineteen years. Of course the problem in trying to rehabilitate these patients would be significantly greater than in the acute wards.

Nevertheless there was opposition to the predominant style of patient care in this ward, not only from nurses working there, but also from the nursing clinicians. One nursing clinician said:

> . . . we have been trying for months in here to make a change. It's a type of functional nursing. We tried to introduce team nursing. That lasted from the Wednesday to the Friday. Then back to functional nursing on the Monday.

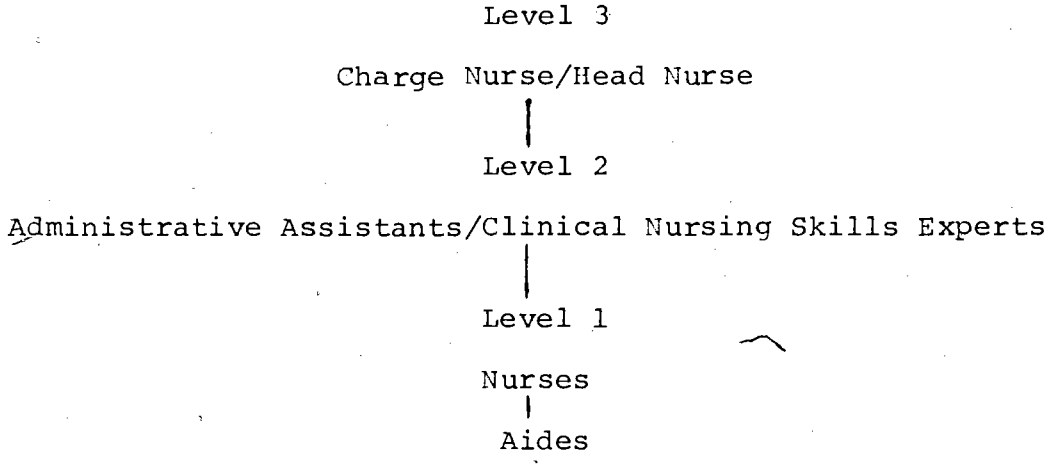


Figure 2. WARD NURSING STAFF

On the wards then, the charge nurse, or the head nurse, is termed a Nurse 3 in the hospital organisation. The only official difference between a charge nurse and a head nurse

is that the former is qualified in psychiatric nursing whereas the latter is a registered general nurse. All nurses at this level had the responsibility of running the ward; generally supervising admissions and discharges; supervising the other ward nursing staff; orientating new staff and new patients; determining whether patients were being treated and cared for in the required manner ; seeing that the doctors' orders were carried out, and assessing particular nurses. They were also responsible for attending ward rounds, reporting to the psychiatrists and discussing patient treatment, and attending regular meetings with the other charge nurses and the nursing supervisors to discuss policy and problems.

At the next level down the hierarchy were Nurse 2's. This level was divided into two categories - the administrative assistant and the clinical nursing skills expert. Each acute ward and East 2 - organic brain syndrome - had at least one of each nurse at this level. The administrative assistants dealt, as the title suggests, with all the administrative work pertaining to the patients. They were expected to be acquainted with the patients and also to carry out some of the regular duties of a psychiatric nurse in dealing with the patients. They were however, somewhat more autonomous than the clinical nursing skills experts. These Nurse 2 clinicals, as they were

referred to, were in charge of supervising the other nurses in their everyday duties. They were also expected to organise staff orientation programmes and to ensure that the nurses were aware of new techniques and ideas. Generally their job was to see that adequate treatment and care were provided in the ward setting.

Next in the ward hierarchy were the Nurse 1's. They were expected to carry out orders from those above them in the hierarchy, and to act with other staff members in 'teams' in dealing with particular patients. In this capacity they were expected to observe and interact with the patients, obtain data for clinical assessment, suggest approaches which might be helpful for particular patients, and help by collaborating with other staff members in administering treatment. They were also expected to care for the patients' basic health requirements and to ensure that the patient maintained certain standards of dress, hygiene and sociability. (see Appendix D). The Nurse 1's in the acute wards were all trained as psychiatric nurses and some were also trained as general nurses. On the other wards, some of the Nurse 1's were not trained in psychiatry.

At the bottom of the scale were the untrained nurses, the aides. Officially they were expected to help the patients with personal hygiene and other related practical issues. They were also expected to help the Nurse 1's in

carrying out their duties. While they were not seen as therapists, officially it was recognised that they could help in the treatment process, by talking to the patients, and eliciting information. They also accompanied patients to Occupational and Recreational Therapy, and to the dining room. Altogether when I commenced the research there were 96 nurses, 41 aides and 9 summer relief aides. By March 1977 there were 55 nurses and 20 aides. (see Appendices E and F)

During this period the medical staff consisted of six psychiatrists on average, one physician, an anaesthetist and the Hospital Medical Director. The psychiatrists were allocated patients in more than one ward, and some practiced only a time in the hospital. The physician, not trained in psychiatry, was employed in East 2, and the anaesthetist worked in the Operating Room.

The psychiatrists were directly responsible for their patients for diagnosing them, for prescribing treatment programmes and finally for their discharge. The psychiatrists met with the nursing staff on a regular basis to discuss their patients, and while they listened to the staff's suggestions relating to progress or changes in treatment, they were ultimately in charge of the patients. This fact as will be seen in Chapter VI gave rise to problems and was a source of potential conflict

in the ward situation. Treatment prescribed by the psychiatrists varied on an individual basis, but all made use primarily of chemotherapy, largely the major tranquilisers - the phenothiazine drugs.

The other 'therapists' were the social workers, who under the auspices of the Social Service Department in the hospital, were assigned on the basis of one to each ward. They were expected to attend ward rounds, associate with the other staff in the nurses' office, and to attend meetings with the patients and staff. They did not deal directly with every patient. Patients were referred by staff members or patients' relatives, and the Social Services Department then considered the suitability of those patients and whether they should become active in a specific case. This was then discussed with the patient's psychiatrist. The social workers were primarily concerned with planning for patients' discharges, assessing the after-care treatment which might be required, acting in liason with community psychiatric agencies in deciding which patients should be referred to boarding homes, intermediate care homes or to local mental health facilities for out-patient follow-up treatment.

Day to Day Activities

The day on each ward started at seven when the morning

staff came on duty and the patients in the 'acute' wards started to get out of bed and ready themselves for breakfast. The patients were also required to make their beds and tidy their locker areas. On East 2 the nurses helped each patient with these tasks and in some cases, helped to feed them. Patients in East 2, surgical, for the most part, remained in bed. On the acute wards the patients (apart from those in the pyjamas category and those confined for other reasons to the wards) took breakfast and their other meals, in the patients' dining room, which was located in a separate building, immediately adjoining Crease Clinic. For those patients above "Level 1" or the equivalent - those not confined to the ward - the day included recreational and occupational therapy. The time allocated to these activities lasted from eight-thirty to eleven, and two to four. The period from eleven to one was designated for "Patient lunch and relaxation."

Within Crease the Recreational Department had one staff member. Activities were organised four mornings per week, and were open to all patients within the unit. The therapy consisted of exercises to music, indoor sports such as pool and outdoor sports and ball games in the summer. Once a week there was a meeting where the patients could discuss the various activities and make suggestions for alternatives. The recreational therapist with

the help of available nursing staff also organised swimming and bus outings once or twice a week. A dance for the unit was also organised once a week.

Occupational Therapy, with three staff members, provided facilities and instruction in pottery, cooking, painting and other crafts. Quizzes, general discussions and 'interaction' groups were also organised. Patients were referred to Occupational Therapy by their psychiatrists, and were then assessed by the therapist for assignment to a particular group. The general philosophy behind Occupational Therapy was to provide a centre, outside the ward where the patients could be encouraged and instructed in social and practical skills. The occupational therapist for each ward would in turn participate in ward rounds, giving progress reports and other general information on ~~each patient~~.

In West 3, the social worker conducted 'Transactional Analysis' groups, for the patients three or four times a week. These groups involved the patients and any staff member not otherwise occupied. According to the social worker, the theoretical and practical background to this was largely derived from the writings of Eric Berne. (cf. Berne 1966). While Berne admits to the possibility of using a variety of therapeutic techniques and approaches within Transactional Analysis, the basic goals concern

the reorganisation of the patient's personality and the examination of stereotyped relationship patterns, within the context of the group situation. The basic intention is to analyse the interactions as they occur in group sessions and to identify and make the patients aware of their particular idiosyncratic patterns of interpersonal behaviour. Berne (1966: 8-10) recommends that once an approach is adopted and the patients are made aware of the goals these should be adhered to. This was explained to the patients but the practical clinical context, in which I observed these groups made adherence to goals a difficult problem. Digressions from the 'group task' were frequent and not readily controlled. In reality most of the interaction in these groups took place on a superficial level. While some patients acted in the required manner, others emphasised their complaints about the hospital food, concentrated on gossip, and generally discussed matters not related to their personal 'problems' or the group situation. Such discussions were considered to be disruptive to the group and were discouraged. Nevertheless this was a frequent occurrence. After one group, the charge nurse and the social worker were discussing one patient, who had behaved in this typical manner.

> She's hopeless, I've never met anyone who went off the point so much That often happens, but she distracts everyone. We went into the group and she said "I read the newspaper this morning about these two people found naked." She always does that.

Those patients who were given grounds privileges were allowed to walk around the large park-like area in which the hospital is situated, participate in various activities and visit certain facilities. Clear rules for behaviour were laid down, and supervisors patrolled the entire area to enforce them. Although there was an emphasis on friendliness to other patients and staff, overfamiliarity and indiscretion were discouraged. Patients making sexual overtures to other patients, or found involved in sexual activity were severely reprimanded. Any behaviour observed and considered undesirable was adequate grounds for warning, which if unheeded, resulted grounds privileges being withdrawn. (see Appendix G).

Certain patients were also involved in some type of employment provided by the Rehabilitation Department. This Department concerned itself with all Riverview patients and was located in a separate building. Two or three rehabilitation staff members were assigned to deal solely with Crease Unit. Patients were given work placements in the industrial division, the paint shop,

television repairs, the laundry room, stores, the linen room, the library and in the rehabilitation workshop. The workshop took contracts from outside the hospital but also dealt with contracts relating to the needs of the hospital. At any given time about 25 percent of the hospital's patients were employed full time by this department.

In Crease the decision as to which patients should work was made by the psychiatrist in conjunction with the other ward staff, and was based on certain information regarding the patients' motivation, personality and so on. The rather loose criterion was whether the patient could benefit from work placement. It was not necessarily those patients who were nearing their discharge who were involved in rehabilitation. In fact those patients were encouraged to look outside for future employment. The problems involved in this and in relating rehabilitation to any therapeutic programme, were widely recognised by the hospital staff. This was exemplified in a statement by the person in charge of the Rehabilitation Department.

> They don't want to do this work - there's very little pay. In practice they are not here long enough and don't want to or don't manage to work when they

> leave, so it is a delusion to think we are preparing them to work effectively outside. 1

Those patients remaining on the wards played cards, listened to the radio, or watched television in the evening, or read. The nurses and the aides sometimes joined the patients in the day room, and encouraged the patients to talk about themselves and their problems. Evening activity for the patients either took place in the wards, or at the various activities provided by the hospital recreational therapy staff. These activities included one weekly dance, one weekly movie, and the occasional bingo session. There was also a bowling alley and a gym. These activities were open to all Riverview patients, other than those confined to the wards.

Those patients in East 2, for the most part were considered incapable of attending Occupational Therapy or Recreational Therapy, although there were usually two or three who did so, accompanied by staff members. Most of the patients in this ward simply sat around in arm chairs most of the day, watching television or listening to the radio. Nursing concentrated on physical aspects

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1 "Them" "they" or "theirs", in quotations, refers to patients, unless otherwise stated.

and custodial care. One nursing clinician commented:

> Sometimes you'd think that the walls would fall down if the patients were taken away. They sit around tied to the walls. Some of them have blankets wrapped around them and attached to the windows.

The patients day on West 2 was organised as on any general surgical ward. Nurses attended to immediate physical problems but of course made some allowances for the difficulties of dealing with psychiatric patients. Doctors frequently appeared on the ward, examined the patient and discussed treatment with the nursing staff. While the operating room was not a ward with resident patients, the activities there related to those in West 2, surgical. Day to day life in this area was simply determined by the number and type of operations to be performed, and post surgery patients were generally transferred immediately to West 2.

The nursing staff on all the wards were on shifts from seven until ten past three, three to ten past eleven and eleven to ten past seven. The ten minute overlap allowed for a summary of the activities from the previous shift and a report on the patients, to be passed over to the oncoming shift. The charge nurses came on duty at eight in the morning, and worked until four. They

did not work shifts, and were only on duty on weekdays. Medications were given to the patients after each meal and before bed, according to the prescriptions ordered by the patients psychiatrists.

From eight-thirty until eleven in the morning, most days the psychiatrists came to the wards for their various ward rounds. Each psychiatrist came once or twice a week, and these sessions ranged in length from half an hour to two hours. In these ward rounds, a nurse brought all those files of patients allocated to that particular psychiatrist and the psychiatrist discussed each patient with the nurses, social worker and occupational therapist. The amount of discussion varied according to the length of time the patient had been in the ward, whether the staff perceived any changes in his behaviour, and whether he had been acting as they thought desirable. Changes in medication, and practical details such as 'grounds privileges,' day or week-end passes, future patient employment were also discussed. In short, all those aspects of the patient and his activities which the staff considered central to his treatment, were reviewed. On occasions the patient under review was brought to the meeting, either for reasons of illustration, or to elicit information. Obviously, these discussions were longer when a patient was first admitted and when his dis-

charge was being debated.

The nurses on the 'acute' wards could participate in any of the activities attended by the patients, and were obliged to attend ward rounds if they were the leader of a particular 'team', or were particularly involved with specific patients being discussed that day. At all times, the 'team' idea of nursing was loosely organised. Before the opening of West 4 as a locked unit, these teams in the acute wards were structured with several nurses in groups attending to several patients, under the jurisdiction of a psychiatrist.

At most times during the day, a number of nurses were to be found in the ward office, where nominally they attended to paper work. However, a great deal of the time spent in the office was in conversation with other nurses. Stanton and Schwartz (1954:157) found that these conversations were closely related to the nurses' immediate job. I found however, that this did not always take the form of serious discussions about the patients on the wards. Quite frequent talking points were non-hospital personal matters.

Devereux and Weiner (1950) found that nurses, during the course of their day, were caught between such activities as administrative, medical and domestic work, and interaction with the patients, the emphasis and time being spent

on the first three activities. I found that this varied among nurses. The amount of time spent by each on these activities and their rationalisations depended to an extent on how they defined their jobs. This can be seen as representative of the conflict and the lack of certainty facing the psychiatric nurse in defining his or her role. This was possibly most problematic for those nurses in East 2, the organic brain syndrome ward, where interaction with the patients was frequently one sided, and with no obvious results, either short or long term, but where being therapeutic was considered officially as part of the job.

The Future Role of the Hospital

Over the past 20 years, psychiatry has increasingly been concerned with dealing with certain types of patients, outside of the large institutional context. Increasingly, those patients have been dealt with in out-patient facilities or in psychiatric wards in general hospitals. This of course was made possible with the introduction of the phenothiazine drugs of the 1950's. Increasingly too, large institutions have been criticised as inhuman and ineffective by the public press, by social scientists and even from within the psychiatric profession.

This trend is reflected in the growth of alternative

facilities in Vancouver, and their employment in the treatment of the psychiatric patient. Psychiatric wards in the general hospitals, the Health Sciences Centre at U. B. C., and community care teams, now deal with patients who previously would have been detained at Riverview. It was recognised by all concerned with psychiatry, that Riverview's patient population was not only declining, but that their admissions were qualitatively different. It was within this context, that it was deemed necessary to hold a conference to discuss the functions and roles of Riverview, at the present and for the future, and to try to formulate a policy, whereby all aspects of the psychiatric facilities in Vancouver could be organised into a continuous, non-overlapping system of treatment and care.

On my first day at the hospital, I overheard several references to changes which were about to be implemented within the hospital. I asked several staff members about these changes, and met with varied responses. One administrator said that so far there had not been any changes, and that they just did not know what was going to happen. The charge nurse on West 3 however, considered that there was every likelihood that one ward would be closed down and that staff would be moved.

The impending conference seemed to be the basis for the multiplicity of rumours and the obvious anxiety, per-

vading Crease Clinic at this time. As Charge Nurse Walsh[2] 2 on West 4 said:

> Well we just don't know where we are. They are meant to be redefining the whole hospital and our roles, changing the concept of the place. They may even close down Crease Clinic completely. They say they will close down this ward. But they may not. We don't know whether to plan for new types of patients. It would be more a closed type of admitting ward. We could carry out programmes for the patients here just now, but again it may change. It leaves us very uncertain. It reflects in the staff and the patients too. You know that we have just appointed the first non-medical superintendent of the hospital. That may change things too.

The conference itself was held on May 17th and 18th, 1976, and it was attended, not only by Riverview administrators, supervisors, psychiatrists and nursing staff, but also by representatives from other psychiatric facilities in British Columbia. I went to this conference, having some idea at the time, that it could have significant implications for my research.

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2 All staff names have of course been changed.

Several recommendations, which had previously been endorsed by Riverview psychiatrists, administrators and senior nursing staff, were examined. The first recommendation (and one of the central issues at the conference) concerned the need for a specialised admitting ward to serve the needs of:

> A: Any in-patient facility within the province which acknowledged its inability to contain or control a specific patient at some point of his illness.
> B: Form 'A' Warrant. (i.e. magistrates warrant for the apprehension of a person believed to be mentally disordered and dangerous to be at large.)
> C: Riverview Hospital in-patients who are temporarily uncontrolled in their 'home ward.' 3

It was also proposed that, other than for those areas in British Columbia without local psychiatric in-patient units, Riverview should cease being a primary referral centre.

At the introduction to the Position Paper, one psychiatrist concerned with organising the future changes, cited examples of typical referrals to the Intensive Care Unit

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3 All such information relating to the conference is taken from the Riverview Position Paper 1976, and the official Responses to this Paper.

in Crease Clinic, from other psychiatric facilities in the province. He emphasised the need for an expanded area, similar to the Intensive Care Unit, given the growing recognition and need for a locked ward to contain certain patients. Two typical case histories that he used for illustrative purposes are outlined here.

1. A 25 year old man is walking naked on the streets of Vancouver . . . His friends chase him back to his house, where he barricades himself and attempts to set the house and himself on fire, believing that for his sins, he must go through purgatory. The help of the police is solicited and he is taken to the Vancouver General Hospital Emergency, given an injection and kept in a side room where he proceeds to prepare the last supper from his own excrement. Then he breaks a window to see the blood flow - the blood he believes of Christ, crucified. He is dispatched to Riverview Hospital where it takes two weeks in a locked setting to control his psychosis.

2. A 28 year old man is admitted to St. Pauls Hospital where a psychiatric facility has . . . been established. He has slashed both arms in about 40 places. He is placed on constant attention, but attacks a nurse and attempts to escape. The patient was transferred to Riverview where the services of

our I.C.U. were again summoned.

This psychiatrist went on to discuss the problems that the various psychiatric facilities in Vancouver have in attempting to deal with such patients, particularly given their reluctance to use seclusion. Riverview, he argued, can take care of these patients, if the facility, that is a locked ward, is provided and staffed. This facility, as well as providing intensive psychiatric treatment, would also fulfill an 'asylum' function, not so much in the sense of being a place to detain patients indefinitely, but as a type of 'secure retreat' for patients with difficulties in the outside community. It was repeatedly mentioned, at the conference, that there was a type of patient who wished an enclosed locked ward setting, for this very reason. The same psychiatrist said:

> There is nothing pernicious about a locked ward. In fact it is quite surprising how many patients, they say I'm in here, I've been identified as sick, I accept this restriction, and so on. They're all temporary and the idea of West 4 is not to be a permanent holding unit, it's just that at some stage of any individual's illness, he needs to be in a setting which can be controlled.

The paper presented by the Head of the Department of Psychiatry at Vancouver General Hospital supported this

discussion.

> Some psychiatric patients are not suitable for general hospital psychiatric care. All our patients are voluntary; we do not have the facilities for managing certifiable patients. . . However, it must be realized that we try, usually for no more than five days to treat all acutely psychotic patients. . . We feel that psychiatric patients in general hospitals should not be kept in for more than six weeks. If they still require extended hospitalisation they should be sent to a mental hospital facility. The general hospital can manage most acute cases but we do require a facility in which long term patients may be placed. The only facility like this is Riverview. Premature discharge from any hospital can lead to disaster, murder, and suicide included.

That Riverview should become almost entirely a secondary referral centre, and that already most admissions were readmissions, was emphasised by the hospital's Director of Nursing. Many of the speakers emphasised that there was a certain type of patient who did not benefit from general hospital psychiatric wards, and whom the general hospital wards did not want. These were generally defined as transitory, and chronically disturbed. In practice it would seem that this type of patient would be referred almost immediately to Riverview, but some reservations were expressed regarding this procedure.

Several other issues relating to Riverview's future role were also discussed. These included the problems of organic brain syndrome patients, of alcoholism and drug dependency, of adolescents and of 'anti-social' personalities. While these issues were important both to the hospital, and to the mental health facilities in British Columbia generally, they are not of particular concern to our discussion.

At the time the conference was being held, opinions as to its nature and the possible outcomes varied. The administrative staff generally saw it as a crucial stage in the development of the hospital. One nursing clinician however, considered such discussions relating to change as reasonably frequent occurrences, and concluded that very little would result from this particular conference. Some of the nurses were quite cynical as to the possibility of any change at all.

> Charge Nurse Walsh: The only way to make any impact and change at Riverview would be to bomb the conference room. Get rid of all the top brass, and then maybe there would be some small change around here.
>
> Charge Nurse Sangster: I know how to get some change - we can take a few of the anti-social personalities and put them in charge.

Yet another nurse saw it as quite useless:

> Every few years they get together and say all sorts of things. At the end of it, they say 'well it's very good,' they have all this input, but they never do anything with it. They all just meet their old friends and have a good time.

On the other hand, Charge Nurse Walsh expressed support for the idea of the locked admitting ward, as being an 'asylum.'

> Yes it's very important. It would be just wonderful, beautiful. There are just some people who need somewhere to get asylum and be cared for with some dignity and privacy.

The conference and the related issues are important to our concerns for several reasons. The public image of Riverview is that of a 'last resort', both for the patients and the staff. The staff, as I shall show later in Chapters IV and V, were aware of the type of patients they had to deal with and the problems involved in 'treating' them. This awareness, in turn would seem to reflect back, in the type of treatment and care given to the patients. The conference, in defining Riverview as a 'secondary referral' area, as a 'last resort', for the other Vancouver psychiatric facilities, served to clarify these conceptions. For some of the psychiatric medical and nursing

staff, this was problematic. The conference was also important, in that it marked the beginning of a period of change, which I was to observe over the year. The uncertainties and insecurities relating to this change were constant preoccupations of the nursing staff and affected their attitudes to the hospital, to the administration, and to their everyday work.

CHAPTER III

PSYCHIATRY AS A PROFESSION: THEORIES AND PRACTICES

The Development of Psychiatry

Today psychiatry would seem to pervade many aspects of Western society, psychiatrists being called upon for their opinions on anything from politics to interior room design. Increasingly, human problems become defined as requiring medical help, and essentially life experiences are seen as problems to be helped by psychiatry. As an ever expanding field, it would appear to include increasingly more persons within its jurisdiction.

Within psychiatry itself however, there is a plethora of contradictory, sometimes conflicting ideals. As Strauss et al (1964:6) point out:

> . . . all that psychiatrists have in common besides patients - and a few psychiatrists do not even have these - is a medical degree. If one includes

> psychoanalysts in the group known as 'psychiatrists' then psychiatrists do not even share that one professional certificate.

This problem is no less complicated when psychiatry is put into practice, particularly within the hospital context.

In considering this problem it will be necessary to examine the divergent psychiatric ideologies which exist and are put into practice in different situations. It is also necessary to consider who receives psychiatric treatment and care, who is defined as mentally ill, and the processes involved in these definitions. Of course in considering those patients in the mental hospital, we are not dealing with all people who receive psychiatric care. As we saw in the last chapter, those patients admitted to Riverview are not representative of the overall 'psychiatric population'. The nature of hospitalised psychiatric patients affects the definition processes, the ways in which the psychiatric profession views its clients, and psychiatric ideologies as they are practiced, in a particular way. The actual interaction situation between therapist and patient is also crucial, in that it reflects the complexity and lack of scientific certainty inherent in modern psychiatric practice. Firstly however, the development of psychiatry and concepts of mental ill-

ness must be examined.

Psychiatry itself has developed as a 'scientific' discipline only over the past one hundred years, and various ideologies have waxed and waned in popularity during this time. It has been argued that societies have always found some method of designating members as 'mad', 'bad', or 'ill'.(cf. Alexander and Selesnick, 1966; Torrey, 1972) It could be said that there have always been people with definitions of reality opposed to the prevailing norms. That which is considered 'mad' has changed over time and is historically and culturally relative.

Foucault (1965) has discussed the connection between the disappearance of leprosy and in the apparent increase in madness in thirteenth century Europe, and the leper as scapegoat was replaced by the 'madman'. Those institutions which had been used to house lepers either closed down or were filled with 'incurables' and 'madmen'. By the end of the Middle Ages 'madness' and 'madmen' were figures of central concern in society. Foucault (1965:24) argues that in the Middle Ages, madness was considered a vice and the madman was denounced, but with the Renaissance, societal definitions and perspectives changed. The meaning of insanity had become of central concern in the literature and philosophy of the time. By the seventeenth century, in the age of "the great confinement", institu-

tions had been created for the containment of the poor, the unemployed and the insane. (Foucault, 1965:30)

Szasz (1971:15) has compared the belief in witchcraft and the persecution of witches to the treatment of mental illness - the "persecution of the insane". Western man he argues, found justification for the persecution of witches in religion, the scriptures, the Church and the inquisition. More recently, man found justifications and explanations for the "oppression of the mentally ill" in the ideology of science. (Szasz, 1971:323) This Szasz argues, involved the transformation of religious ideology into a scientific ideology; medicine replaced theology, the inquisitor became the psychiatrist and the witch became the madman. Szasz concludes that the result was the substitution of a medical mass movement and ideology for a religious one.

Beliefs died away which had considered witches and the insane as people to be abandoned or destroyed and more 'humanitarian' approaches developed. Society's general attitude towards the treatment and care of the mentally ill had changed by the end of the eighteenth century. This was paralleled by increases in scientific knowledge which reflected developments in scientific medicine in general.

The development of psychiatry as a discipline can be

traced in quite a different way, that is by examining the various trends in aetiology, diagnosis and treatment, which have been dominant in all societies. Alexander and Selesnick (1966:26) find these to be: a) the organic approach - attempts to explain diseases of the mind in physical terms, b) attempts to find psychological explanations for mental disturbances, and c) attempts to deal with inexplicable events through magic. The first two represent the main ideologies dominant in psychiatry today. The definition of psychiatry as a scientific discipline makes the third trend incompatable. However, the impact of the 'magical' perspective can be recognised in the actual practice of psychiatry, which would at times seem to be based more on faith and hope than on scientific and rational procedures.

The organic approach most obviously parallels the development of modern scientific medicine. Mental illness is primarily regarded as an 'illness just like any other'. Theories of illness are essentially biological and are concerned with the conquest of disease within the body. (Mechanic, 1968:91) This scientific approach looks for specific symptons of a disease and concentrates on curing these entities which are conveived as being separate from the body in which they are located. Throughout the past 300 years this approach has developed rapidly and achieved

dominance in medical thought. We will see, however, the organic perspective in psychiatry is problematic in that there is conflicting scientific evidence concerning the nature of mental illness, and those therapists subscribing to this ideology do not always agree on the aetiology, diagnosis and treatment of mental illness.

Psychological approaches to the understanding of human nature have always been present in societal thought although 'normal' behaviour was not considered worthy of analysis until comparatively recently. Abnormal behaviour was originally connected with an almost magical definition of illness. Some of these ideas, which we shall discuss more fully later in this chapter, may occasionally affect the approach taken by present day psychiatrists, particularly those adopting a psychotherapeutic mode of treatment.

The psychiatric profession as we recognise it today began to assume its present shape at the end of the eighteenth century. This was largely influenced by Pinel's teachings and his humanitarian ideas concerning the treatment and care of the mentally ill, Pinel himself reflecting the philosophies of the Enlightenment. His releasing the patients at the Bicetre from their chains in 1793 is now regarded as a progressive step and hailed as an historic occasion particularly by those who see psychiatry

as a scientific discipline directed towards the curing of the mentally ill. Pinel believed that mental illness resulted from heredity and life experiences and thought that it should be studied by the methods of the natural sciences. (Alexander and Selesnick, 1966:152) Pinel's ideas are expressed in his famous statement:

> . . . I am convinced that these madmen are so intractable only because they have been deprived of air and liberty. (Foucault, 1973:242)

After it was discovered that the hitherto named illness "general paralysis of the insane", was in fact caused by the syphilitic spirochaete, psychiatrists were encouraged to search further for organic causes of mental illness. (Clare, 1976:42) This, with the growth of psychological knowledge and the development of psychoanalysis, further contributed to shaping the discipline of psychiatry as we understand it today. The various historical trends are diverse and could be discussed in detail. However, it is adequate for our purposes to understand the bases upon which present day psychiatry was built.

Psychiatry is certainly not a unified discipline, and it is even less so when the various ideologies are put into practice. As Strauss et al (1964:7) argue, there are still deep divisions and even conflict in the psycho-

logical versus the biological approaches and the individuals who represent these diverse approaches talk in almost different professional languages. In general we can assume as Strauss et al (1964:8) do, that the ideologies which exist today fall broadly into three categories. First the somatic, second is the psychotherapeutic and third is what can be called milieu therapy.

The somatic approach is psychiatry is basically concerned with finding physical causes for mental illness, and thus physical remedies. It is an organically based ideology which is founded on similar principles to those of scientific medicine in general.

The psychotherapeutic ideology is concerned with a wide variety of factors relating to the individual and his psychological make up. Aetiology and treatment from this perspective includes a multitude of theories which generally concentrate on such matters as early childhood experiences, self-image and interpersonal relationships.

The 'milieu' approach overlaps to a certain extent with the psychotherapeutic. It places more emphasis on the importance of environmental factors in aetiology and treatment. All of the above mentioned ideologies will be expanded upon in the following section.

Ideologies do not remain static. While they reflect their historical origins, they are continually modified in

the practical context. It will become apparent that psychiatry in the hospital, while it may adhere to one dominant ideology and mode of treatment, is practiced in a situation where conflicting ideals, conflicting therapeutic roles and practical everyday problems relating to the patients, all contribute to an ever changing, accommodative and essentially confusing therapeutic situation.

Contemporary Psychiatric Approaches

There are some therapies commonly employed in most psychiatric hospitals. The predominance of each therapy in the practical situation, however, depends as will be discussed, on certain factors such as the institutional structure and its historical perspective, the psychiatrists' and nurses' therapeutic ideologies, and the diagnoses of the patients. It is necessary at this point, to outline briefly the most commonly used treatment methods in psychiatry today.

One of the major somatic therapies is electroconvulsive treatment. It was first introduced by Cerletti and Bini in the 1930's and became established as an important physical method of psychiatric treatment. The method involves the passing of an electric current through electrodes applied to the scalp in the area of the temporal lobes of

the brain, thus inducing a convulsion. (Clare, 1976:228)

It is argued that electroconvulsive therapy is successful in the treatment of depression, although the evidence would indicate that this is not so in all cases. Of all the studies undertaken to examine its efficacy few have used control groups and those have not demonstrated that E.C.T. is actually therapeutically effective. (Clare, 1976:231) Moreover, while it may reduce certain symptoms, it does not attempt to treat the underlying causes. While the evidence would seem to indicate that it is effective in reducing certain depressive states, there is little agreement within the psychiatric profession as to its efficacy in the treatment of schizophrenia. Despite this lack of supportive evidence, E.C.T. is sometimes used either where there is no indication that it might be successful, or as a 'last resort'.

I have frequently observed situations where E.C.T. was given as a matter of course, or where no other treatment method seemed to be effective with a particular patient, or where one member of a therapeutic team manipulated other more psychotherapeutically oriented members into agreeing to this treatment, as an action which possibly would have immediately observable results. In such an eclectic discipline as psychiatry where scientific cures and results are rarely forthcoming the therapists quite

understandably are frequently willing to use any method with possible results. Partly as a result of this, and partly because of the search for an immediate answer to psychiatric problems, E.C.T. is frequently given, again in the hope that it might work with a particular patient.

The psychiatric profession cannot adequately explain how or why E.C.T. seems to work in certain cases. Biochemical processes are continually being examined in relation to E.C.T. but no final explanation as yet exists. (Clare, 1976:256) One of the side effects of E.C.T. - temporary memory loss - has also been advanced as an explanation for its effectiveness in that the patient forgets what led to his depression. Finally it has been argued that E.C.T. acts as a punishment; a patient reacts to the shock as he would to a punishment, a negative reinforcer, and he ceases being depressed as a result.

Another physical therapy employed in psychiatric hospitals is psychosurgery. One technique is the pre-frontal lobotomy, and consists of sectioning the frontal lobes of the brain. Although the actual physical effects of this operation on the brain are obviously known, the effects on the patients' personality and behaviour are not. The earlier technique of pre-frontal lobotomy has undergone major sophisticated neuro-surgical revisions and present

operations do not have the same drastic effects of incapacitating the patients' memory or congnitive skills as was previously the case. Psychosurgery is an infrequently performed prodedure today, and it is generally claimed that it is a last resort when all other methods have apparently failed. This therapy was not generally employed in Crease Clinic itself, and would rarely be used in such short-stay, acute psychiatric areas.

The entire nature of psychiatry, of hospitals and of the care of the mentally ill generally has been drastically modified since the introduction of the phenothiazine drugs which were first introduced into North America in 1951. The use of these reflects the hope which has developed in the evolution of general medicine - that there are drugs which will cure all physical and mental illnesses.

Chemotherapy as used currently, is based predominantly on the major tranquilisers - the phenothiazine derivative drugs. These act principally on the lower brain centres producing relaxation, supposedly without motor impairment. While the physical effects have been well documented, knowledge really only concerns the symptoms. While these drugs may relieve the symptoms of certain illnesses, it has not been demonstrated that they 'cure' the basic illnesses. Antidepressant drugs are the other main form of chemotherapy used in psychiatric hospitals today. Lithium

is another with widespread use in psychiatry. It is used not only as a treatment for manic episodes, but as a stabiliser to prevent the future occurrence of extreme elation and depression. (Clare, 1976:140)

In general drug therapy is used simultaneously with other types of therapy. But it is drug therapy which has generated most optimism for the future cure of mental illness. It is also a financially well supported area of research. Investigators are continually hopeful about discovering a chemical basis for mental illness and hence a chemical cure, particularly in the problematic area of schizophrenia. Meanwhile psychiatrists continue to use chemotherapy, not because they know it cures mental illness, but because it controls certain symptoms. In effect the treatment is based on a certain amount of 'unscientific' hope. This is exemplified in the following statement.

> . . . there are many practitioners of psychiatry who have as little face-to-face interaction with patients as possible and who concentrate in all good faith upon physical therapies. (Strauss et al, 1964:7)

The psychotherapeutic approach itself is complicated and populated by diverse ideologies and practices. However, all psychotherapeutic approaches, according to Frank (1961a:2) are characterised by attempts to heal through persuasion.

He outlines those points which they have in common and which apply not only to modern psychotherapies but also to methods in primitive healing, religious conversion, and even 'brain washing'. They are:

> a) a trained and socially sanctioned healer whose healing powers are accepted by the sufferer and by his social group or an important segment of it
> b) a sufferer who seeks relief from the healer
> c) a circumscribed more or less structured series of contacts between the sufferer and the healer, through which the healer often with the aid of a group tries to produce certain changes in the sufferer's emotional state, attitudes and behaviour. (Frank, 1961a:2)

It has been argued that modern psychotherapies have their historical roots in two traditions of healing - the religio-magical and the scientific. (cf. Frank, 1961a; Torrey, 1972) Healing in the former case was traditionally conducted by a therapist who combined the role of priest and physician. The healer when dealing with any illness using this type of therapy, would be concerned with relating the sickness to a wide range of circumstances in the patient's social life. (Horton, 1970:345) Treatment involves eliciting information from the patient concerning his self-image, and his relations with his social group,

and is similar to the methods used by modern psychotherapists with their emphasis on confession, disentangling complex social and interpersonal problems, in the hope of bringing about the resultant change in the patients' attidues and behaviour.

According to Frank, psychotherapy emerged as a distinctive form of healing in the late eighteenth century, with Mesmer, who demonstrated that he could make the symptoms of certain patients disappear by putting them into a trance. While his methods were discredited, mesmerism was the precursor of hypnotism. Towards the end of the nineteenth century, Freud discovered that many of his patients' symptoms seemed to be symbolic attempts at expressing and resolving conficts which had their bases in early life experiences. The treatment which followed was based on detailed explorations of the patient's personal history in the emotional reliving of these childhood experiences. (Frank, 1961a:4)

The other branch in psychotherapy was behaviourism, developed from Pavlov's experiments with dogs. He found that these dogs could be made 'neurotic' by exposing them to insolvable problems. Behaviourism is generally associated with psychology, however, in institutional psychiatry, those principles are frequently adopted particularly in the form of behaviour modification. Behaviour modification

is frequently used in psychiatric hospitals, often alongside somatic and other psychotherapeutic models of treatment. According to Atthowe and Krasner (1966) the purpose is to change patients' behaviour from being overly dependent, apathetic, or annoying to others, to their being able to perform routine activities associated with self care, to make decisions and to be more future oriented. While behaviour modification may not be the major therapy prescribed by the psychiatrists in the practical situation, it is frequently used in the everyday interaction between therapists and the patients. In the psychiatric hospital, nurses and sometimes psychiatrists often use this therapy in order to run the ward smoothly. They will reward 'good' behaviour, and likely punish undesirable behaviour, not necessarily consciously considering their actions as 'therapy', but simply as a response to everyday problems incurred in the ward situation.

There is a multitude of theories and literature concconcerning psychotherapies, it will however, be adequate to outline briefly some of those which are predominant in contemporary psychiatry. In the practical context, as I observed it in Crease Clinic, various psychotherapies were employed but they were not strictly based on any one theory. Rather the psychiatrists and the nurses were inclined to adopt an eclectic approach. The following

psychotherapies which I discuss are those which basically relate to those described and observed in Crease.

Frank (1961b:42) outlines his theoretical framework for activities in group and individual therapy . Generally he sees neuroses as maladaptive responses, resulting from disturbances in the normal processes of growth and maturation. These arise from conditions, particularly in early life, which do not afford suitable opportunities for growth, or which lead to chronic anxiety producing situations. As a result, the individual grows up with conflicting urges and feelings, not easily resolvable. Psychotherapy then, as conducted by Frank (1961b:44) involves supplying a new interpersonal situation which helps the patient find more effective ways of handling his chronic interpersonal and internal conflicts. The therapist he argues, should try to support the patient emotionally and offer him a situation where relearning is facilitated. Other people may be used in the group to help give support to the individual.

Rogers (1961:94) sees the psychotherapeutic situation as the promotion of growth, development, maturity and improved functioning of the individual. He emphasises the importance of the "helping relationship", and is concerned primarily with personality change in the client.

Psychotherapy may also take place involving the entire

family unit. (Ackerman, 1961:228) The main point of reference is the inter-relation between the illness in the individual and the functioning and mental health potential of the entire family. Ackerman (1961:242) argues that diagnosis involves finding criteria for classifying family types, evaluating the integration of the individuals into their family roles, evaluating emotional disturbances in the family dynamics and generally analysing the interdependence between the individual and the family as this relates to mental health. Therapy consists of making explicit any disturbances in the interaction patterns, and thus facilitating relearning.

Transactional Analysis, developed by Berne, is based on the assumption that people have 'scripts', which are sets of transactions that they have learnt in their childhood and which they have a tendency to repeat. Group therapy provides information in revealing these scripts, and those which are not considered beneficial to the individual are analysed and options are given in the hope that the individual will relearn these transactions. (Steiner, 1974:16) As had already been mentioned, this type of therapy was specifically used by the social worker in Riverview's West 3.

For the most part however, those psychotherapies which

were practiced in the hospital were not specifically related to one particular theory. As will be discussed, when psychotherapy is used in the clinical context, it is not only practiced on the same patients by different therapists and in conjunction with other modes of treatment, but it is also practiced to a certain extent on an ad hoc basis. Psychiatrists and nurses developed their ideas about psychotherapy on the basis of their training and through personal experience, and adapt their approaches to deal with different patients who may not be amenable to particular therapies, or in situations where for practical reasons the application of such therapies as mentioned above, may not be possible. Thus psychiatrists and nurses working in hospitals are faced with a variety of problems, which almost inevitably lead to an eclectic therapeutic approach.

Therapists and Patients

In general, when we consider the relationship between the therapist and the patient, all treatment procedures do have certain processes in common. As Frank (1967:169) argues, a principal feature which all healing relationships have in common is the patient's reliance on the therapist to relieve his distress. Even where treatment is involun-

tary the patient is led to expect relief from the psychiatrist.

Both of the actors, the healer and the patient have certain expectations in the therapeutic situation, although under certain circumstances, these may conflict. However both parties have prescribed acts which they are obliged to undertake. As Goffman (1959:27) maintains;

> . . . a given social front tends to become institutionalised in terms of the abstract stereotyped expectations to which it gives rise, and tends to take on a meaning and stability apart from the specific tasks which happen at the time to be performed in its name . . . when an actor takes on an established social role, usually he finds that a particular front has already been established for it.

When the patient confronts the therapist he has an image of the therapist's role and how it should be performed. This image reflects the social definition of the therapists' role, combined with the conceptions formed by the patient through past experience. (Mechanic, 1968:163) There are specific rules involved in the interaction situation which have to be followed for a successful outcome. The patient is expected to do what the therapist tells him, to describe what is wanted fully and accurately and to have confidence in his judgement. (Mechanic, 1968:174) The patient is also expected to be dependent on the therapist's authority and if he brings into question this authority, he may invoke

a conflict situation.

The role of the healer, the placebo effect, and the importance of suggestion are continually discussed in the medical, psychological and sociological literature. These ideas may not only apply to psychological, but also to any method of therapy. As Welbourn (1969:17) argues, any general practitioner who is aware of what he is doing knows that a great deal of his practice is based not on pharmacology, but on magic. The patient hopes that the therapist can help him and faith in the therapist may be healing in itself. Much of the influence which the therapist has on the patient is non-specific and results from his position of authority, his suggestive powers and influence strategies. (Mechanic, 1968:185)

A great deal of the relevant literature discusses the authority of the therapist and the subjugation of the patient to it. It is possible to draw an analogy with the position of the film director and the actor. The director/therapist controls and directs, imposes limitations on behaviour which is necessarily channelled through facilities given by him. The patient/actor will thus be forced into a role performance. Once he has learned his lines and conducted himself in the correct manner, the patient will be allowed to continue. When he performs the role adequately, he is relieved of the responsibility for

his actions and he will be treated.

Schatzman (1972:185) also argues that in the case of the psychiatric interview, a satisfactory role performance is required on the part of the patient. If the individual does not play the part adequately, it may be said that he is not motivated to regain his health. This extends into the everyday ward situation, where, as will be seen, the therapists impose their expectations on the patients, and non-compliance is frequently labelled as 'inappropriate behaviour'.

According to Roth (1962:576) the goals of the professional and the patient are never entirely the same. The goals of the professional in his relationship to the patient tend to be specialised, his role is equivalent to his status position. The goals of the patient, however, include goals generated by all his roles. The treatment relationship, he continues, may be seen as conflict for control of the patient's behaviour. This is usually resolved by a process of negotiation. While the outcome of the whole interaction, as Saunders and Hewes (1960:402) report, depends on the attitudes, values and expectations which all the participants bring to the situation, the therapist will generally impose his assumptive system on the patient. Similarly, Scheff (1968:12) discusses the psychiatric interview and the negotiation which takes place. The interview takes the

of a series of offers and responses that continue until an offer, a common definition of the situation is reached, and accepted by both parties. The outcome of this negotiation largely depends on the power of the interactants. The fact that the therapist is in a position of authority, his definition will likely prevail.

The other variable which is important in this situation is the confidence of the healer himself in his theory and method of treatment. In areas where there is a validated body of knowledge and effective treatment has been demonstrated, such as in the treatment of infectious diseases, the confidence of the physician rests on his knowledge and mastery of techniques. However, as has been discussed above, the psychiatrist and the nurse, are in a dilemma due to the nature of psychiatric practice, and the problems relating to effective treatment. As Freidson (1970:169) points out;

> How could a present day psychiatrist work if he really believed the careful studies which emphasise the unreliability of diagnosis and the undemonstrability of the success of psychiatry? And how could physicians work one, two, or five centuries ago?

Frank (1967:175) states that they rely on allegiance to a group of like minded individuals for their emotional confidence. Their training will have indoctrinated them into a particular ideology. Not only does their training

help them in this dilemma, but the fact that they have experience and have managed to function in this particular professional capacity, gives them additional confidence to rely on their own judgement and to continue what is essentially unpredictable, subjective and unscientific treatment.

Psychiatric training itself may encourage this latter approach. Freidson (1970:169) also discusses the fact that psychiatrists in training are sometimes encouraged to value experience as opposed to "book-learning" and "intellectualising". Nurses too, may also face similar situations although, as will be seen, there are certain differences between Canadian and British approaches to training with regards to this, which gave rise in Crease Clinic to a great deal of potential conflict and hostility.

The therapist may use several techniques to protect his fallibility. A patient who does not conform to the therapist's position may be characterised as 'resistant' or 'manipulative'. If a particular case is unsuccessful the therapist may maintain his faith by saying that the patient broke off treatment too soon, or he may say that the patient was not adequately motivated. (Frank, 1967:183)

While various theories of psychiatry, both somatic and psychotherapeutic have been outlined, and the processes involved in treatment have been discussed, the problem of

who receives treatment and under what conditions, has yet to be touched upon. If we consider psychotherapy at its broadest, the thousands of North Americans who receive some form of such treatment cover a population which at one extreme includes what Frank (1961a:12) describes as mental hypochondriacs. At the other, are people who are classified as 'ill' and are suffering from severe disturbances of thinking and behaving. The latter for the most part make up the population of the mental hospitals such as Riverview. The former, to a certain extent, are included in the above discussion, but we are not in this case particularly concerned with their treatment. Their increasing numbers however, may be important when considering the place which psychiatry has in society today.

The Problem of Mental Illness

If there is any doubt as to the lack of certainty within psychiatry, this can be dispelled when the position of the patients is considered. This argument is quite simply based on the definitonal problems of mental illness. There is a mass of literature on this matter, but it is quite well illustrated by a World Health Organisation study. (Sunday Times, 1973:13) The W.H.O. used a computer programme to check on diagnoses made by psychiatrists in nine different

countries. 1202 patients and 90 psychiatrists took part in this survey. Each patient was examined by a local psychiatrist and a comparison was made with the W.H.O. standard. It was discovered that in both the Soviet Union and in the United States, patients are classified as schizophrenic who would be diagnosed in quite a different way in another country. Some patients who were diagnosed in this way were classified by the computer as suffering from depression or mania. The conclusion was reached that psychiatrists do act as agents of the society, reflecting not only their training, but also certain societal attitudes. Other studies have indicated similar discrepancies when the diagnostic process is analysed cross culturally. (cf. Clare, 1976:125-135)

Canada was not included in these studies, but the dominant psychiatric ideologies in Canada reflect the United States model more so than the British. On the other hand, many of the psychiatrists employed in Canadian psychiatric hospitals were trained in Britain, and so therefore it would be expected that schizophrenia would be less frequently diagnosed in the Canadian system than in that of the United States.

While there are certainly these discrepancies cross-culturally, it is possible to over state this argument. There would certainly seem to be some core symptoms which

are internationally recognised as indicating schizophrenia. (Clare, 1976:123) Of course schizophrenia is not the only mental illness, but quite a large percentage of those patients admitted to Riverview, particularly as it has become defined as a secondary referral area, have been diagnosed as psychotic. There is also a great deal of debate concerning the aetiology, prognosis and treatment of psychotic illness such as schizophrenia.

It would be possible to argue endlessly over what is mental illness and what causes it, but that is not the main concern here. It is adequate to recognise that there are problems in diagnosis, and that this is realised by hospital psychiatrists in their everyday work. In the mental hospital setting however, the causes of the illness are not so much the main concern as the treatment. Research into aetiology is largely the domain of university psychiatry departments. In the large psychiatric hospital such as Riverview, various factors such as time pressures and the conflicting ideologies of co-workers necessitate that the psychiatrists immediately identify an illness and work, in a pragmatic fashion, towards trying to alleviate it. That is not to say that psychiatrists ignore the patients' social and psychological backgrounds. As will be seen, those psychiatrists interviewed at Crease Clinic stated that they used this information both in the diagnostic process and

in their treatments. While we can accept that most psychiatrists do work within a medical model of mental illness, as Scheff (1966:16) argues, that is they are centrally concerned with the individual and his illness, to define the medical model as narrowly as has been done particularly by anti-psychiatrists, is to do dis-service both to the profession and to the psychiatrists themselves. The medical model does take into consideration the individual's personal and social status, as a significant factor of his illness. (Clare, 1976:69)

As mentioned earlier Szasz likens the mental patient to the witch. Szasz does not claim that certain social disturbances or the particular personal conduct do not exist, but he argues that as men once created witches they now create mental patients. Men he says are often accused of mental illness and are persecuted by involuntary hospitalisation and treatment. In Szasz's view these people are either persuaded to submit to treatment or are forced to do so. (Szasz, 1971:21) He argues that the typical mental patient in the United States today is like the typical European witch in the fifteenth century, that is they are usually poor and in trouble. Again Szasz argues that the social role of the mental patient is established by the combination of authoritative opinion, widespread propoganda and popular credulity.

Involuntary hospitalisation is a controversial topic. Under 25 percent of patients admitted to hospitals in Britain do so under compulsory certification, while this same figure in the United States is around 80 percent. Under the Mental Health Act 1964 of British Columbia, involuntary admissions may be made under the certification of two physicians, after a complaint has been made by the patients friends or relatives, the police or even;

> anyone who has reason to believe that the person is mentally disordered. (Mental Health Act 1964 section 23.)

To summarise, in discussing involuntary hospitalisation Szasz presents a particularly extreme, almost conspiracy theory view of psychiatry. Any understanding of the processes that lead to a patient being admitted to a psychiatric hospital indicate that frequently the societal and interpersonal processes are quite subtle. Even though some people do seek help by themselves, individuals frequently arrive at psychiatric hospitals after covert and overt pressure by others. Family and acquaintance pressures may be involved in this process.

As discussed above, the definition of mental illness is essentially problematic. It is not particularly simplified by considering it as a type of deviance, an approach often taken by sociologists and criminologists. Most norm

violations do not result in the violator being labelled as mentally ill, but as ignorant, ill mannered, sinful, criminal and so on. There is however, argues Scheff (1966:34) a residue of diverse kinds of violations for which the culture provides no explicit label, and these are lumped together into a residual category called 'mental illness'. The problem however is that in psychiatry today, all norm violators are coming under the rubric of mental illness. The increasingly pervasive nature of psychiatric ideology sees the whole of society, all deviants, perhaps even all non-deviants, as potential customers.

The problem is taking a deviancy approach and saying that the process involves the violation of norms, is that it begs the question, whose norms? In practice the situation would seem to depend considerably on the individual concerned, other's expectations, the person's normal behaviour and his status in society. Certainly it would seem that those in more powerful positions in society are more likely to get away with 'eccentric' behaviour and not be labelled as mentally ill.

The crucial question for Scheff, is if residual rule breaking is highly prevalent among 'normal' persons and is usually transitory, what accounts for the small percentage of residual rule brakers who go on to deviant careers?

The societal reaction approach may be viewed from two interrelated positions, from that of the actor and from that of the audience. The self concept of the actor is a crucial dependent variable, and the audience's reaction is important in the labelling process. A person will go on to a deviant career according to Scheff if his behaviour is defined as evidence of mental illness. The audience must react to the individual in a way which leads him to enact the expected role (of being mentally ill). Alternative roles may be cut off so that the one offered is the only way the individual can cope with the situation.

Mechanic (1968:45) found that friends, family and community authorities were all involved in this process. Similarly Lemert (1968) considers that internal, political, and social psychological processes in small groups, although not necessarily families, lead first informally and then formally to the expulsion of the deviant from the group. Evidence relating to this however, is contradictory. Yarrow et al (1967:45) found that some families almost bend over backwards to avoid the hospitalisation of their members. Their research indicates that women utilise strong defences to avoid recognising their husband's behaviour as deviant, and try to interpret it as normal. Knowledge of these processes can help the psychiatrists when they are making their diagnoses and, as will be seen, may be even more useful when

it comes to treatment and post-hospital arrangements.

Other variables may be involved. These might include the family's social class and its ability to conceal deviant behaviour. For example, the middle class family may be able to cope with the problem and protect the deviant, while this is less possible for the working class family whose financial resources are limited. While it is impossible to know the extent to which mental illness may actually exist within the population it can be seen that lower class persons are more likely to arrive at a hospital like Riverview. This of course could be accounted for by several explanations, including those mentioned above. It may also be that middle or upper class patients are generally dealt with in alternative facilities such as general hospitals. It could also be that patients in hospitals like Riverview are actually reacting to undesirable social conditions, and even occasionally choose to go and remain there, quite simply because the surroundings are more congenial than anything they could find outside in the community. As will be seen this is a frequently discussed topic by the nursing staff, who are often of the opinion that patients do not want to leave Riverview. The discussions at the Riverview conference, mentioned earlier, relating to the need for an 'asylum' ward, would also seem to reflect these ideas.

Of course the family has been viewed from another angle, as contributing to mental disturbance. (Laing and Esterton, 1964) Behaviour which is regarded as symptomatic of mental illness, they argue, is often just rebellion against 'tyrannic' and 'bizarre' behaviour by the parents. It is difficult to know whether this is another example of labelling or whether the children in question are actually driven 'crazy' by the situation.

It may be that by the time the individual arrives at the psychiatrist's, all others concerned and possibly the individual himself even if he did not wish to comply in the first place, will believe he is ill and in need of treatment. Mechanic (1968:198) argues that the psychiatrist, on the arrival of the potential patient, will likely assume that illness exists, and will apply a label to the alleged, if not recognised, symptoms. In the two hospitals studied by Mechanic all new cases were recommended by the psychiatrist for treatment. Psychiatrists would seem to operate under the assumption that it is better to judge a well person sick than vice versa. Scheff (1966:135) also found that the procedures involved in admitting a patient were largely automatic and ritualistic. Illness was presumed on the individual's arrival.

This type of situation has frequently been observed and documented. It is usually necessary for the psychiatrist

to apply a diagnostic label to the new patient. Although there is provision for non-diagnosis, such designation is infrequently used so in a sense there is a tendency to recognise that a person who has come for treatment must be sick. This problem however, is not immediately recognisable when it is related to the situation at Crease Clinic. As I found during my field work incoming patients had usually been admitted sometime previously. They were part of the 'revolving door' phenomenon. As Crease was largely a secondary referral unit, these people, even if they had not been in Riverview before, they had been through the psychiatric system in one way or another and had been diagnosed previously. So not only did the therapists have a great deal of information relating to the patients' past illnesses, but the patients themselves knew some details of this information and were familiar with their roles as mental patients. So while the processes which led to the individual arriving at Riverview may have been similar to those mentioned above, the diagnostic process was even more straightforward, as was the patients' assumed roles. Very few patients arrived at Crease Clinic with no understanding of what was expected of them or of the therapists.

As mentioned above the entire orientation of psychiatry may be changing. Psychiatry as a discipline is an ever

expanding field, enveloping more and more persons into its domain. Szasz argues that the human need for help and the professional-technical response to it form a self-sustaining cycle which transforms more and more human problems and situations into specialised technical problems to be 'solved' by the mental health professionals. This commenced with the identification and classification of mental illness, and has culminated with the claim that all of life is a psychiatric problem for the behavioural sciences to solve. (Szasz, 1973:4)

The recent trend for example has been to regard even criminals who were previously at least given credence for knowing what they were doing, as sick and so vulnerable to psychiatric treatment. In considering this psychiatric expansion, it is helpful to include Illich's thesis on health and sickness in general in Western society. He calls this 'clinical iatrogenesis', which involves all clinical conditions for which remedies, physicians and hospitals are pathogens - essentially sickening agents. (1975:22) This medicalisation of society "trains the patient-to-be to function as an acolyte to his doctor." He comes to depend on his doctor in sickness and health, and so turns into a life long patient. (Illich, 1975:50)

The development of the Community Health programmes may also be a manifestation of this process. The conference

relating to the future role of Riverview would seem to confirm these ideas. Some of the central concerns of this conference included the development of Community Health, of smaller more manageable psychiatric facilities, of areas for alcoholics, drug addicts and adolescents. This situation need not necessarily be accepted at face value as the taking away of power from the mental hospitals and other traditional means of treatment and care, but rather a manifestation of the increasingly growing nature of the mental health profession, which seems to include increasingly more problems within its jurisdiction.

Chapter IV

THE PSYCHIATRISTS: ORIENTATIONS AND PRACTICES

Perceptions of the Wards

The various ideological orientations discussed in the previous chapter was generally adhered to by the psychiatrists in Crease Clinic, as were the therapies and modes of interaction with the patients. All the psychiatrists interviewed and observed held similar viewpoints regarding mental illness and treatment, and operated in similar fashions in the course of their everyday work. As we noted earlier, however, psychiatrists develop their ideas about mental illness and treatment on the basis of their training, through personal experience and adaptation to the work situation in general. As a result of these experiences each psychiatrist placed different emphases on the variety of psychiatric ideologies and treatment methods.

Of the four psychiatrists interviewed, three had been

trained in Britain, while the other was trained in British Columbia. These training experiences are reflected in the ideas stressed by the individual psychiatrists concerned. British psychiatry has long been dominated by an organic approach to treatment but in the United States, as Clare (1976:67) points out, both psychoanalysis and somatically based clinical psychiatry have been predominant. Canadian psychiatry in so far as it emphasises an eclectic approach would seem to be more like the American model than the British. The training requirements for Canadian psychiatrists include experience in general hospital psychiatry, in outpatient community care, in psychosomatic medicine, as well as in neurology. It is also required that the trainees work in a hospital caring for psychotic patients and in facilities dealing with children, adolescents and the mentally retarded. The learning of long term methods of therapy in dealing with psychotics is also emphasised.[1]

For those psychiatrists trained outside Canada, it is generally necessary that they sit the Canadian examinations before being allowed to practice in Canada. This requirement is waived in the case of Government employees. Nevertheless, all three psychiatrists trained in Britain and working in Crease, had obtained Canadian Certification by the time I finished my field work.

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1. **cf.** The Royal College of Physicians and Surgeons of Canada. Speciality Training Requirements in the Medical and Laboratory Specialities, 1975.

Dr. Treadwell after completing his residence, worked for nine years before coming to Canada in 1969. Since that time he worked at Riverview. Dr. Langton completed his training in 1973, when he came to Canada and worked in a general hospital for two years before commencing employment in Riverview. Dr. Smith had worked in Riverview since 1968, after completing his psychiatric training in England. Dr. James was the only psychiatrist interviewed to have been trained in British Columbia and completed his training in 1973.

Each ward had an 'official definition' which had been decided on by the hospital administration. For example East 4 was "open admitting", West 3 was "open intermediate" and West 4 was "open continued care", later becoming "closed admitting". The type of treatment and care considered appropriate by the administration for each ward was defined by these titles. The four psychiatrists working in the acute wards played an important role in redefining these specific ward orientations and the type of treatment administered. These psychiatrists were interviewed after East 4 had been closed and while the Clinic was in the process of change. The psychiatrists defined the wards generally in terms of the type of patients housed therein, and specifically in terms of the patients allocated to them.

> Dr. Treadwell: . . . primarily the patients who are in West 4 are acutely sick and when they come from outside they are acutely sick and you have to immediately get them into some active treatment. By that I mean you could have somebody who's tearing the place apart the first time you see him you have to do something. It's an emergency thing to start with.

The patients on West 3 on the other hand were seen as more manageable and in the psychiatrists' view, more amenable to treatment.

> Dr. Langton: The patients in Riverview as a whole are psychotic, not neurotic types or personality disorders, so that pretty much confines what you are going to do ... the difference between West 4 and West 3 would be in the degree of disturbance and in the degree of disorganisation, so again the emphasis would be, between the two wards would be in the proportions of medication related to the degree of disturbance . . . the other psychological based therapies, O.T., R.T., rehabilitation and so forth will be introduced at a certain point, which is the point of suitability of improvement, in West 3 where we think they can respond to treatment.

Dr. Smith agreed entirely with this definition of the different functions of the two wards.

> Dr. Smith: When they first come in they end up in West 4 and that's when I make a diagnosis, because without this I wouldn't know which medication to use . . . because most patients are psychotic . . . and up there on West 4 I would be talking more about symptoms and then down here (West 3) they can get down to talking on a wavelength, communicating.

On the other hand Dr. James admitted to no difference between the two acute wards. When asked, "is there any difference in what you do in this ward (West 3) and West 4?", he replied:

> No it is exactly the same. It's just a matter of one being a closed ward and one being an open one.

Nevertheless there was general agreement (over the nature of the patients in the acute wards) and this was shared by the nurses and was reflected at the conference. As Dr. James stated:

> Now Riverview Hospital has come to be known as the setting that can handle effectively the violent, the aggressive, the really psychotic and in fact all of the general hospitals have given us that role . . . so that shows how we are used.
>
> Dr. Smith: I think the types of patients we are getting would be the so called severely disabled patients - patients who the other hospitals couldn't handle.

This was considered desirable by some of the psychiatrists but undesirable by others because of certain perceived problems. The major problem seemed to be in terms of manpower, as was emphasised by the hospital's Medical Director.

> We're in a kind of a bind in that the college has . . . I think they are setting incredibly high standards, and I don't think there are enough psychiatrists.

Some of the ward psychiatrists voiced the same complaint. Dr. Treadwell saw this problem as one which affected his everyday work, and as a result, the effective treatment and care of his patients.

> Well one thing is the number of patients a doctor has to deal with, to look after, you just cannot do everything you want to do when you have admissions coming in. They just walk into the office and you have a new admission. So that day is ruined, whatever you had planned for the day is gone and you find that you told a patient that you were going to see him tomorrow morning and you find you can't.

There was some support however for limiting the types of patients admitted to Crease. Riverview's newly defined role was seen as advantageous by the organically oriented psychiatrists.

> Dr. Langton: I believe that people who are neurotic need not be treated by medically trained people. I firmly believe that we should concentrate our efforts. We have a manpower shortage and if we diffuse our efforts to every human problem under the sun, we end up being very inefficient. So we should just concentrate on one small area where we can make good use of our training.

This in turn relates to the problems and issues involved in the Community Health programmes, and the expanding field of psychiatry, which was discussed in the last chapter. One psychiatrist emphasised the undesirability of this situation.

> Dr. Smith: I think psychiatrists have been assuming too much responsibility for the society. Some of us have been making fantastic claims about what we can do, we promise but we don't deliver . . . We can't prevent crime or drug addiction or alcoholism . . .'I'm quite upset about the guy who received a life sentence last week for kidnapping and raping this young girl and he was sent for treatment . . . because some psychiatrists say he has a 50/50 chance of responding. In fact why can't they say they don't know, instead of a 50/50 chance. In fact we have been too patronising towards people, tried to take responsibility, so that when people get into trouble, they say it's not my responsibility, it's my illness, I'll see my shrink.

Quite the contrary point of view was advanced by Dr. James. He supported the idea of widespread community care, and considered that all human problems could at least be helped by the psychiatric profession.

> We can only treat them right now (alcoholics) on the grounds that they are dangerous to themselves or grossly disturbed. I have many cases on record of problems with alcoholics or even glue sniffing, where we feel very powerless. My personal inclination is that these people cannot look after themselves very well and they pose problems to all members of society and I don't see anything wrong in getting them to receive treatment.

The other major problem in limiting the admissions to Crease on a secondary referral basis was what was termed the 'revolving door syndrome'. The process involved admitting a

patient, who stayed for a few weeks, was then discharged, and then was readmitted sometime later. This was recognised as a continual process for many of the patients. It was however seen as inevitable, and not simply a result of the redefining of Riverview's role. This was a process which had been ongoing for several years and is generally recognised as a problem in institutional psychiatry, and not simply one which was peculiar to Riverview. With the growth of outpatient facilities and acute psychiatric wards in the Vancouver area, however, this phenomenon was aggravated in Crease. These other facilities were admitting acute short-stay patients only, and were referring to Riverview, all patients who could not be dealt with or who were in the process of becoming part of the 'revolving door syndrome'.

> Dr. James: I would say that the stay (in Crease) on average, is longer than in the acute general hospital and that is why the general hospitals send their patients to us, because somehow their construct is such that they cannot accommodate a patient beyond say four weeks. Most of them see four weeks as a sort of cut off point and somehow they are under pressure to get rid of the patient and so we can provide for longer than four weeks.

Reactions to this phenomenon varied, both among psychiatrists and nurses. We shall see in Chapter V that

some of the nursing staff considered this much more of a problem for their everyday work than did the psychiatrists in general. The psychiatrists at least did not admit to this being a problem for their professional work, or for their role definitions, although they were in a relatively advantageous position compared to the nurses in that they could always retreat behind professional detachment. Some of the nursing staff adopted a similar solution to the perceived problem. While disillusionment on the part of the psychiatrists was not expressed overtly, it may be that this was reflected in other ways. A number of the psychiatrists working in Crease were part time, and were increasingly taking other part time positions in community psychiatric facilities. It could be that this was a result of a desire on the part of the psychiatrists to see clear results in terms of treatment and discharge into the community. In general however, those psychiatrists had rationalised the 'revolving door' phenomenon. In Dr. Smith's words:

> Let's face it. In medicine, in any branch you cannot guarantee cure. People will relapse, be it diabetis or heart disease. I can see only a few specialities where there is real cure - in obstetrics or perhaps orthopaedics. I would say it depends on one's expectations. With many of my patients I would say even if they manage to stay out eight months a year and manage to function reasonably well and they are feeling reasonably comfortable with themselves, happy with what they do and relate to people of their own choice and having them come back to us for

> a month or two because of a relapse, I would say that's an achievement. It's much better than having to keep a patient here for years and years without letting the person go because of the possibility a person might relapse. I don't call this a problem, after all we do thrive on problems.

On average the length of stay in Crease for a patient was estimated to be six to eight weeks, although there was extreme variation from this. It was recognised that certain patients required extended treatment and could not be discharged within this period. This was the realisation which prompted plans to open East 2 as an extended care ward. Dr. James recognised this situation.

> I have a portion who would go out in two to three weeks, then there are some who would go out in six weeks, but there are those who have long standing problems, the tough ones and they have stayed up to seven months. . . It's proportional to the severity of the illness.

In general the psychiatrists seemed to accept that even if a patient was discharged within a few weeks, there was an extremely high chance that he would be readmitted. Nevertheless this did not seem to result in disillusionment on the part of the psychiatrists and it did not lead to any questioning of their beliefs in the efficacy of psychiatric treatment or of their own roles as healers. As was mentioned previously, psychiatrists adapt to the everyday work situation

and define their roles on the basis of the possibilities imposed by the institutional structure and by the types of patients being treated.

> Dr. Treadwell: We do see them coming back, it is a revolving door thing. You do what you can do - send them out and sometimes they have follow ups. In fact we have all the teams active in Vancouver, and the chances are good that they will be looked after and maybe kept out of hospital, but in spite of the best intentions, people do come back. We keep seeing the same patients over and over again, with a few new admissions.

Within the limitations of psychiatric treatment and knowledge this doctor accepted the problems of constant readmissions and in fact emphasised certain beneficial aspects of the situation - knowledge of the patient's previous history was seen as time saving if not conducive to an effective treatment situation.

> Dr. Treadwell: . . . schizophrenia is a recurring type of illness and any kind of stress might precipitate another relapse and they're going to have to come back, you have to take that into consideration. Besides if they've returned, the nurses know already . . . so everybody knows what's needed.

Only one of the psychiatrists placed the blame elsewhere for the high return phenomenon and this was with the community outside. Dr. James was perhaps the most confident

of the psychiatrists in his therapeutic approach and in his ability to deal with patients.

> As far as my personal approach is concerned, my return rate is pretty low. I get these things under control from the start . . . the legal system, the family system and medication . . . so most of the problems can be dealt with in the follow-up setting. Nevertheless there are return rates and they return usually because the system breaks down . . . There's a continuity of care, I know the patients well. Sometimes it breaks down because of lack of support from the family, usually an overprotective mother, or no family.

The psychiatrists working in the acute wards then, shared rather similar definitions of the ward situation and of the patients housed therein. For the most part they also had rationalised the problems encountered in treating these patients. Despite these common understandings as will be seen, each psychiatrist subscribed to different psychiatric orientations and modes of treatment in the same wards.

Role Definitions and Psychiatric Ideologies

The realisation that Riverview was admitting mainly psychotic patients did not seem to be a dilemma for the psychiatrists, as far as treatment was concerned. This was much more of a preoccupation for some of the nursing

staff. This was probably due in part to the fact that psychiatrists' roles were quite clearly defined by themselves, by the administration and by the other therapists. As was mentioned in the previous chapter, psychiatrists in the practical hospital setting are not always concerned with causes of mental illness, but are rather more preoccupied with treatment. This was exemplified in statements by two of these psychiatrists.

> Dr. Smith: It's nice to say that one not only treats mental illness but one should prevent illness. But let's be frank, in psychiatry we do not know the aetiology of a lot of the psychiatric illnesses and unless we know what the real causes are, it's purely academic to talk about prevention, so I'm studying at the other end - symptom oriented.
>
> Dr. James: You move on to a one to one basis once they become accessible, but the main thing always at the back of your mind is you want to get this patient on his own two feet as soon as possible and then get him out to treatment on the outside, follow-up. So it doesn't give you much time to get a long programme, you know, planned, investigative therapy, you have to do that, look into their backgrounds, but at a minimal.

Dr. Treadwell was the only psychiatrist interviewed who would discuss the aetiology of mental illness, but he did not indicate that he adhered strongly to any particular theory.

> I don't know what causes psychoses. The evidence points to genetic, biochemical origin, but that doesn't mean environmental stress cannot trigger off abnormalities. My belief is that for the common problems we deal with here, such as schizophrenia, there might be some environmental cause. By environmental I mean not just psychological, it could be an infection, some systemic disease, but I would think that a person has to be genetically vulnerable to develop such illness.

The simple definition of patients as 'psychotic' or 'unmanageable' however, does not adequately explain differences in attitudes to therapy itself. Each psychiatrist had specific ideas as to how treatment should be carried out and how patients should be dealt with. While each subscribed to a particular psychiatric ideology, chemotherapy is one of the predominant modes of treatment in institutional psychiatry today, and in general all the psychiatrists agreed that this was so in Crease.

> Dr. Treadwell: . . . You have to use medication and so on until they settle down and once they become more accessible there's a few other things you can do. But the medication is the main thing in these wards, in this hospital.

> Dr. Langton: . . . the occasional patient does not respond to certain medication and you try a whole range of medications, and they're acutely disturbed and we find that they're not responding getting worse, then maybe with that kind of patient the process will have to shift from medication to psychological treatment, even though they're psychotically ill.

Dr. Langton seemed to imply that other treatments would be of secondary consideration. Dr: Smith was even more emphatic in his support for chemotherapy.

> Because most patients are psychotic and I firmly believe that one of the most important treatments during the psychotic phase is medication . . . As for the other aspects, I don't know whether they should belong to psychiatry or not, the aspects regarding health, growth maturity and so on. I really think these are beyond my realm.

Although it is difficult to generalise on the basis of this sample, it would seem that despite the additional training and the practical experience obtained by the three non-Canadian trained psychiatrists, they still to a certain extent reflected their original British orientation to psychiatry. As Dr. Smith agreed:

> Training does have some bearing. My training was primarily medically oriented organic approach. That would be the trend in England. Here it's you might say, more dynamic, more psychological really, with emphasis on the intrapersonal rather than the biochemical perspective. I suppose I try to approach the person, I still call my approach a medical model, because I'm primarily a physician first. I'm more disease oriented . . . Frankly I cannot define what health is. I treat symptoms.

On the other hand the locally trained psychiatrist emphasised that he used chemotherapy in conjunction with

other therapies, and that the former was not necessarily predominant.

> Dr. James: We have a moderate proportion of psychoanalytic ideas and also social manipulation and medical treatment, that is the standard thing. I am certainly using an eclectic approach - social manipulation, family intervention and proper use of chemical medication.

He was not alone in his use of therapies other than drug treatment. Despite the general emphasis on chemotherapy and a common recognition that this was particularly useful in the situation in Crease, where acutely disturbed, often violent patients were admitted, other therapeutic approaches were recommended by all the psychiatrists. They all emphasised the need for personal contact with the patients, although time limitations and a high patient count prevented the psychiatrists from devoting their entire working day to this. In general, when they were not at ward rounds, or in meetings, it was possible for the patients to effectively request a consultation during the time their psychiatrists were on duty on the particular ward. All the psychiatrists accepted that some sort of psychotherapy could be effective once the patient had passed through the initial 'settling in' period, but there was no consensus as to how long this period was. In practice it depended on the individual

patient and the nurses' and psychiatrists' perception of his illness.

> Dr. Smith: When a patient is very sick in the acute phase there's no point trying to talk to him, to take him to a community meeting and make him sit there and be bombarded with all these stimuli, because I think at this stage, the poor patient cannot simply handle all these excessive stimuli. I think the patient should be left alone at this stage and concentrate on the medical aspect of treatment.

The other psychiatrists, less oriented to chemotherapy than Dr. Smith, emphasised the need to start on some sort of psychotherapy as soon as possible.

> Dr. Treadwell: I think even in West 4 after a few days, the patients become more accessible and then you can start on one-to-ones.
>
> Dr. Langton: It's all psychology in a way, from the first time you meet a patient, so even if you are concentrating on adjusting medication, your interaction is all important. There's no point in tranquillising them into a stupor and hoping that will get rid of the illness . . . Most patients are regressed in their development, so that interaction is all important.
>
> Dr. James: It's right from the beginning, that's my approach. My orientation is that I emphasise strongly the achieving of goals for the clients which are consistent with the social expectations.

Nevertheless each psychiatrist had an individual approach when it came to therapy itself. Even Dr. Smith, despite his orientation to a somatic psychiatric ideology, considered that his role went beyond simply prescribing medicine.

> Dr. Smith: After you have to deal with the psychological . . . At this stage you should talk to the patient about their attitudes to their illness, whatever negative feelings they have, encourage them to talk about it. It may in itself help the person feel relieved, repair the psychological damage. So by a medical model, I mean the total person. At different stages of the illness we emphasise different aspects of the problem.

Doctors Treadwell and Langton had similar orientations at this stage of the patient's illness, despite the fact that they emphasised different approaches to treatment when the patient was first admitted.

> Dr. Treadwell: Usually at ward rounds we are at the second stage of the treatment. Most of the patients at ward rounds are in a state where they can communicate with people and this is the point where we try to exploit the communication and try to do something about the personal and intrapersonal.
>
> Dr. Langton: I give them time though to talk about their conflicts, their present state family history, what can be dealt with, these are the usual concerns. That is going on all the time and you shift to spending more time concerned with these

> things. When the patient becomes more organised you are able to establish a rapport and dealing with the effects of the psychotic illness, so their depression, their anger, shame, guilt, social stigma.

The patients' family backgrounds were recognised as important by the psychiatrists for supportive therapy after discharge, although it was also realised that the family could possibly have been a contributory factor to the illness in the first place. Dr. Smith discussed this, although he did not consider that family therapy was part of his therapeutic role.

> In most cases the family will need reassurance but very often pathological relationships have been established and you have to do something about that . . . I myself am not trained as a family therapist. I would refer the patient in this case to somebody who was trained in family therapy. I only assume responsibility in those areas I feel competent to deal with.

Dr. James, on the other hand, saw the family situation as part of the therapeutic process, and was concerned to involve this as much as possible in the patients' treatment and rehabilitation.

> I rely substantially on family support and in most cases I think in my experience about 95 percent of the cases, I am able to obtain family support because I think that is the expectation of most of the people involved with the clients.

Each of the therapeutic approaches was not directly based on any one psychotherapeutic model. In the previous chapter we indicated that institutional psychiatrists usually work with eclectic or nonspecific models. What they did have in common, other than a dominant emphasis on chemotherapy, was an approach which emphasised the need for the patients to discuss their problems, to communicate with the various therapists. Dr. James however, had a more coherent approach, and had developed a particular model which was based partly on experience, and partly on his training. Moreover, he saw himself as playing the major therapeutic role in relation to the patients. In essence there were specific responses and results which he aimed at in treating all his patients.

> Dr. James: I understand that before that some therapists did not share the view as I do as far as achieving the goals of treatment, because I understand that the other people believe in the individual freedom, freedom and achieving a person's potential. I feel at the moment I don't belong to the majority, but these ideas are gaining more support now. In the past psychiatric training has been influenced by the Carl Rogers type approach - client centred therapy . . . My orientation is that I emphasise strongly the achieving goals for the clients which are consistent with social expectations . . . a person should be responsible in terms of his behaviour . . . I try my hardest to achieve that. That's what I aim for and how I approach my patients.

All of the psychiatrists working in the acute areas had a variety of patients with different diagnoses. Dr. James was Chinese and dealt mainly with Chinese patients. He considered this to be a great advantage in treating these patients.

> I think this is one area where I can give better service than others who do not speak the language.

Dr. James was able to put into practice the ideology he subscribed to partly because he worked part time at Riverview and part time in community care, where he dealt with the Chinese community. He was therefore able to involve family therapy, and direct rehabilitation towards specific ends. At the same time he could also be directly involved in the post hospital care of his patients and tried to ensure continuity in this way.

It was generally recognised that any in depth psychotherapy was impossible, given the constraints of the institutional setting, the types of patients and the common desire to discharge the patients as quickly as possible.

> Dr. Langton: Because of the nature of our clientele, we are dealing with the most demanding, most aggressive and most sick population and because of this the psychoanalytic approach and in depth psychotherapy in this setting appears to have very limited use.

> Dr. Treadwell: I feel our main job is to get people out of the acute phase and back into the community within a very short period of time. Any ward like West 4, I don't think group therapy would work, because you have such a mixture of patients, of their needs, and group therapy takes time and you just can't get into the meat of it, and it's a regular thing, meet twice a week for months and you don't have that sort of time.

The psychotherapy adhered to by the psychiatrists in Crease then, would seem generally to involve a combination of the various approaches discussed in the previous chapter. (cf. Frank, 1961a; Rogers, 1961; Ackerman, 1961) Despite this, the psychiatrists interviewed represented quite divergent ideological approaches, with Dr. Smith at the organic end of a continuum, and Dr. James at the psychotherapeutic end.

The Psychiatrists at Work

All the psychiatrists, no matter how they defined their roles as therapists, or which psychiatric ideology they subscribed to, tended to remain professionally detached from the patients in the treatment situation. It was argued in the last chapter that the essential element of the healing process is the subjugation of the patient to the therapist. The psychiatrist is fully confident that

if the patient acts out his role in the required manner, and if he follows his instructions, an effective treatment situation will develop. The essential element is the psychiatrist's confidence, which he has gained through experience and training, in his ability to make judgements and prescribe what is best for the patients. This was easily recognised in most of the interaction situations which I observed between psychiatrists and patients. Most of these took place at ward rounds, where it was possible to observe all the therapists together with the patients.

The most conspicuous factor in the psychiatrists' behaviour lay in their detachment and their confidence. At one ward round I observed Dr. Langton, in the presence of three nurses and the occupational therapist, discuss a particular patient who was also present. Dr. Langton presented a detailed history of the patient and prevented anyone else in the room from expressing an opinion. The patient at one point asked, "Am I well now?" Dr. Langton responded: "No, not yet, when I say so, I'll tell you when you're ready." His confidence in his therapeutic approach was obvious when a nurse asked of him: "What good can drugs do when her problem has been no discipline?" He admitted that there was such a problem, but then dismissed it as unimportant and continued his monologue concerning the patient's illness.

A similar situation arose at other ward rounds. Dr. James was conducting the rounds, and one patient, described as "paranoid-schizophrenic" was present. Dr. James asked the patient if he knew he was sick. The patient responded: "I feel ill now, since the shock treatment." Then Dr. James asked: "You mean you felt well before?", and the patient responded positively. The psychiatrist then ended his conversation with the patient and turned to the nurses and the social worker saying;

> You see that's typical of a paranoid-schizophrenic, they just won't accept that anything's wrong.

Problems did occasionally arise however. Another ward round meeting involved Dr. James and a patient with whom he was having therapeutic difficulties. Apparently they had tried a few approaches and had been unsuccessful. As a last resort Dr. James had requested that a behavioural psychologist attend the meeting to give some advice.

> Dr. James: I'm considering aversive therapy and that's why I've asked Mr. Miller to come. This patient's history involves glue sniffing, delinquent behaviour. He seems to have become habituated to glue sniffing, set fire to his legs, and had to have one amputated. The patient seems to be quite willing, (to receive aversive therapy), he says he wants to kick the habit. He's not a psychotic, he's not schizophrenic, but from glue sniffing,

> he seems to display some psychotic behaviour.

The psychologist considered that aversive therapy would not be successful, and explained his reasons to Dr. James. Dr. James was then in the uncomfortable position after having admitted defeat and requesting external help, of having to recommend further chemotherapy and psychotherapy. This type of situation however, was unusual. Generally the psychiatrists believed, or at least acted as if they believed, entirely in their therapeutic effectiveness.

The psychiatrists were also confident that the patients wanted the treatment administered to them. This was particularly obvious when they were defending the physical therapies.

> Dr. Langton: I ask a patient who has been a manic depressive how he felt before and after he was given medication, most patients want medication. Some don't because they prefer the slightly euphoric level, but again the degree of disability can be so great.

Electroconvulsive therapy was the other main physical treatment used in Crease Clinic, although unlike chemotherapy, it was not given as a general matter of course. Certain factors were taken into consideration before it was recommended. The psychiatrists were fully aware of all the adverse publicity given to this type of

treatment and , to a certain extent felt pressured to justify its use.

> Dr. Langton: We have to choose carefully though. The use of it has declined though. We are inclined to use more sophisticated psychological treatments. We had a patient who wanted it, when the indications were well she had schizophrenia with a strong depressive component and she had been treated before. In spite of the discovery that she had a slight cardiovascular problem which we told her about and we discussed it with her husband. So lots of people do want it. It's not a matter of saying that they should have it, or must have it, it's use is declining, but I hope not completely, some people do benefit.

The psychiatrists then, in their behaviour at ward rounds and in their discussions of the patients, demonstrated confidence in their knowledge and abilities. They made diagnoses, prescribed treatment, and while they took reports from the other therapists, their status positions and their actions were reinforced by their beliefs in psychiatry and their subscription to particular ideologies and therapeutic approaches.

It can be argued, and this was voiced by some of the nurses, that psychiatrists, because of their professional detachment, and because of the fact that they were not with the patients particularly frequently, were not always therapeutically effective. On the other hand, many of

the nurses themselves adopted similar role definitions and work styles.

Another factor which could contribute to therapeutic ineffectiveness on the part of the psychiatrists is that they were of a higher social class than the patients. In addition in Crease, the psychiatrists and the patients were of different ethnic backgrounds. While psychiatrists do see detachment as necessary in the therapeutic situation and they are certainly trained in this way, these class and ethnic factors may have counteracted therapeutic effectiveness, given that a basic understanding of the patients' psychological and social problems in an essential requirement for treatment.

Chapter V

THE NURSES: TREATMENT AND CARE ON THE WARDS

Definitions of the Therapeutic Situation

The nursing staff in Crease Clinic had entered psychiatric nursing by various routes; some had been trained in Riverview, and some elsewhere in Canada and of those nurses interviewed, thirteen had been trained in Britain. Some had had experience in general nursing, psychiatric nursing or both; others had had experience in the prison system, other government agencies and psychiatric facilities and some had been trained in Riverview and had been employed there ever since. Their experience in psychiatric nursing ranged in length from six months to 25 years.

The training school at Riverview closed in 1972, the first graduates having completed in 1932 - 1933. This had been a three year course, with experience divided between Riverview, Valleyview and Woodlands. Since 1972 the train-

ing of psychiatric nurses has taken place at B.C.I.T. which offers a two year, largely theoretical course. This was a topic of considerable debate among the nurses trained in practically oriented hospital schools, as was the subject of nurses trained in Britain.

The nursing staff were employed on the wards for most of the working day. They observed the patients' everyday lives, noted changes in their behaviour and attitudes, decided the daily activities, and for all practical purposes, ran the ward system. The nursing staff's attitudes then were probably of major importance in influencing the every day world of the wards, and in the last analysis, the treatment and care of the patients.

The charge nurses had the responsibility of designing, however loosely, a ward philosophy and were in a position, along with the psychiatrists, to introduce certain practices into the ward situation. When Charge Nurse Sangster was first interviewed she was working in East 4, which was officially defined as an "open admitting ward". She did not completely agree with this title, but like the psychiatrists, she based her definition on the types of patients who were being admitted rather than on any ideal of what the ward should be.

> Nurse Sangster: This is no longer an acute area as such. It's not been that for a while.

> We haven't any patients who are strictly neurotic. I don't think we'd know how to deal with them. We have really complex people, who're really very sick, anti-social, the whole thing. You know out of about ten admissions, I only have to introduce myself to about two, and maybe even they have been in the hospital but not in this ward before.

She did not see that the function of the ward was immediate acute or intensive care, but rather she emphasised the rehabilitative aspect of the ward.

> We're trying to involve the patients in their own future. First of all a lot of them have just nowhere to go and no-one, so there's nothing, so the remotivation and rehabilitation is a big job. When we find a little spot of interest, we try to go into develop that way of thinking, looking at the outside.

Another nurse in East 4 emphasised similar perceptions of the ward situation. The 'revolving door' syndrome was an obvious aspect of the everyday perception of the patients and of the definitions of the therapeutic situation.

> Nurse Callaghan: The type of patient has not changed over the past three years since the community care teams took over. We only get the ones they can't cope with. People are sometimes that sick that we can't really cope. We use psychotherapy, milieu and chemotherapy. We involve ourselves in groups, when the patient types lend themselves to it. A lot of effort and time is spent on encouraging them to keep what independence they have, it's always a hellish shock when they get outside.

These comments were made at a time when it was known that East 4 was to be closed, and to a certain extent they reflected disillusionment with the ward and its definition as an acute admitting unit. The realisation that the hospital was no longer receiving acute 'neurotic' patients resulted in certain problems for the nursing staff, both in defining the therapeutic situation and in defining their roles. Like the psychiatrists however, the benefits of this situation were recognised by the nursing staff, or at least they had come to rationalise the problems to a certain extent.

> Charge Nurse Sangster: But most of the people they keep on coming back. Well it makes it easier in other ways, you know what kind of behaviour to expect and they stop acting up once they get here. That's what they wanted, was to get here, and they might keep it up for a couple of weeks and then a lot of them give up.

At the same time, West 4, which was to incorporate the patients and staff from East 4, was defined as an "intermediate care ward". Charge Nurse Walsh described it as;

> Two wards, there's West 4 and I.C.U. They have always functioned autonomously as two areas rather than two sections to one main thing, West 4 is described as being intermediate care, people are not long term, but they are not short term. There are some problems in that they require

> longer to get them back into the community. I.C.U. functions as an intensive care for psychiatric emergency.

When questioned about his ward philosophy however, his ideas did not accord so closely with the official goals and definitions of the ward. The objectives as they had been previously designed for the ward stated that West 4 was to;

> provide intermediary psychiatric care for all referred patients in Vancouver's psychiatric services who are over the acute phase but require longer term treatment than the acute areas can provide. Emphasis is placed on rehabilitation and remotivation. Secondly to provide a period of assessment of each patient upon transfer to the ward so that he can be placed in the various ward and hospital programmes geared to meet his needs and to provide specific nursing programmes designed to remotivate from the level of dependency to the highest level of functioning in preparation for discharge . . .

Charge Nurse Walsh, however, considered that this was merely a vague statement, manufactured by the administration, but had no real meaning or practical guidelines.

> That doesn't mean a damned thing, so that's what's written and prescribed. It's not an operational thing, it's simply a statement. The ward at this point does not have what's considered to be a system of care. We talk about a team and team nursing but we don't have it. It's more or less a free-for-all, functional nursing type of approach.

Other nurses on the same ward agreed with the Charge's definition and recognised similar problems.

> Nurse Phillips: Most of them are a bit chronic. They try to get them out of hospital to boarding homes and things . . . There are too many theories and ideas, nothing specific here . . . To make it functional you really require something consistent.
>
> Nurse Lawless: It depends who's on. There's not enough direction. It's too lax. No way I can function like that.

For West 4 at this time, a large part of the problem for the staff related to patient types, staff shortages, lack of organisation, and the impending changes. While these were matters for frequent complaint, which I heard from a variety of people in different situations the entire time I was doing the field work, they did seem to pertain particularly to West 4, both before and after reorganisation. Before the change the patient types actually were becoming increasingly 'chronic'; they were patients who stayed for several weeks and were part of the 'revolving door' phenomenon. Yet the official definition of the ward situation forced the nursing staff into considering treatment in terms of rehabilitation and early discharge.

> Charge Nurse Walsh: We have very little sort of psychodynamic sort of treatment. Most of our people are severely psychotic with a longstanding history of illness. . .

> we base our programme more on why the person is in hospital. One does not come into hospital because you're mentally ill, you come in because of very specific things that happen. You are either doing things in the community which brought you to the attention of the police, or your neighbours, or you subjectively felt you weren't coping. Some of these things are the things we try to look at.

Nurse Lang agreed with the charge nurse, but she emphasised the necessity for teaching basic skills, and not involvement with the patients' deeper psychological problems.

> Most of our patients have a great deal of problems with loneliness. They tend number one to isolate themselves and live in their own fantasy world. So really it's geared to kind of social skills, hygiene and it's a requirement to cope in this way, our society is obsessed with hygiene and in this way, you can socialise them. I kind of feel that if a person, that is there are many things that can be done with them and we try to get to that. Again there are too many patients for the staff to cope with.

If West 4 was lacking in direction at this point, the Intensive Care Unit was not. The ward definition and the goals were quite specific, and were recognised by the majority of the staff. These goals and definitions, which were discussed at the conference, were to become those of the new restructured West 4.

> Nurse Todd: This is where the action is . . . In some cases it's a worthwhile endeavour. It has advantages for certain patients. . . You can feel as if you might be accomplishing something . . . I've always gone along with the idea of a locked ward, chemical strait-jackets, no. We have a type of a team here. Like today, I'm the team leader. It can get pretty high in here.
>
> Nurse Bean: The worst part of I.C.U. is the tension, if some guy's about to blow his top. Sometimes they like it in I.C.U. they don't know until they come. They come and they find it quiet and secure and they get a lot of attention, with planned therapy.

At this time West 3 had the broadest range of definitions of the ward situation among the nursing staff, and the charge nurse did not admit to subscribing to any specific therapeutic ideals.

> Charge Nurse Russell: We don't have a ward philosophy. We have objectives on the delivery of care. . . We have such a broad spectrum of patients. We start off with the assumption that the patients are acutely ill. They are usually disturbed and very dependent, and we've got to move to letting them be independent. We're not always striving for complete independence.

Some of the other nurses held much clearer, more crystalised, defintions of the therapeutic situation in West 3.

> Nurse Bacon: West 3 is sort of straightforward. It's a more active ward and more responsive patients. West 4 was more slow. The proceedures here are quite straightforward and up to date. This ward is really psychological problems.

> Nurse Henderson: I think the policies of this ward are carried out well. I think pretty well everyone helps the patients make decisions. It's an acute ward, not a physical. But it's very necessary to be aware of the patients and their moods.

On West 3, however, Nurse Benish placed more emphasis on the physical aspects of patient care. This reflected her own role definition, rather than her understanding of the ward definition of the therapeutic situation.

> Well first off, I see our patients, in most instances as being in remission. So I feel our job here is to medicate them. Certainly some type of socialisation, because that's what they lack, social skills, and hopefully get them out into the community because that's what the community set up should be, the more intensive kind of work. I think that's how I sort of see the role of the ward.

One nurse on West 3 did not agree that there should not be identifiable ward goals, and saw the situation at that time as problematic.

> Nurse Cramer: It has to follow through with different shifts, it has to follow through when you move. There has to be a stricter programme. Then all the nurses will know what to do.

West 3 did seem to function quite adequately with much less confusion than the other acute wards, despite its lack of a clear cohesive programme of treatment. Compared to the other wards however, it was in the advantageous

position of not being a central focus of the Unit's reorganisation. It was redefined to admit patients directly from West 4, but its internal structure was not changed. The nurses in West 3, possibly as a result of these two factors, could carry on their work, as they defined it on a day to day basis, with little interference. This is reflected in their role definitions, as will be seen in the following section. It could be that if a ward defines its goals specifically, it opens itself up to interference by the administration. One nurse in West 3 had had experience of such a situation in the past.

> Nurse Robinson: When I worked in an admitting area in another building, we had a fantastic programme going . . . We made the mistake of calling it what we felt we were doing. You know we named what we were doing. If we'd known we'd have been wiser, but we were so proud of what we were doing. We cut down on seculsion hours, we cut down on E.C.T., on intramuscular injections. We had fabulous rapport with the patients but as I say suddenly we named it and we started talking about it and that was that. It was squashed.

West 4, when it was restructured as a locked admitting ward, incorporating the Intensive Care Unit, had a specific policy, a clear definition of the therapeutic situation. The charge nurse from East 4 was transferred with some of her staff and patients to West 4 at this point.

> Nurse Sangster: First of all we assess their need to be on this ward, a locked setting and if that appears unnecessary, then they will have a pretty rapid transfer to West 3, if they have the beds. So there's going to be a lot of chemotherapy, and if we ever get organised, if we get enough time, we'll work out the behavioural aspects of their problems and the interaction with the patients will be pretty intense. There's all sort of things happening at the moment so it's not easy, and it's not because of lack of interest, the people I've got are enthusiastic and they really care . . .whether they're going to like this ward with the high stress factor.

At this stage, the nurses on West 4 generally agreed with the official ward definition, although the problems involved in the new situation were readily apparent to everyone. Disagreement with the ward definition would have been surprising, as the nurses were told why the new West 4 had been restructured, and for the most part, they had volunteered to work there on that basis. Confusion however, existed at every level.

> Nurse Morgan: It's really confused at the moment, nobody knows what the other person is doing. It's frustrating. It's just difficult to get any continuity in the treatment of patients.

Eventually and gradually, the situation in West 4 settled and more specific policies were implemented.

> Nurse Helm: There was chaos and confusion for a while and at that time the patients were high and the staff were a little unsure of themselves. . . Thing is you need team nursing in a place like this, more regular. As far as I am aware they don't have a specific ward philosophy, but it's being developed.

By December of 1976, West 4 was still facing some of these problems, but the administration and the nursing staff were attempting to solve them.

> Charge Nurse Sangster: It's still quite chaotic. The administration has agreed with us that 37 acutely disturbed psychotic patients are far too many, and they've agreed to drop the bed count to 25. . . Our patients are really disturbed, but we're becoming quite able to be consistent. You know if we decide that Johnny can't go to R.T. if he's cursing and swearing . . . we can stick to it. Things are evolving. The successful way is becoming the ward policy and we're developing routines.

Even by February of 1977, the nursing staff were recognising problems with the ward and its therapeutic design.

> Nurse Gladwin: I think we have a good staff here and I think collectively all the staff have good ideas of programmes, but unfortunately with wards moving out of the building and wards coming in and our bed count going to be reduced, until such time we can't bet an effective programme going.

Not all of the nurses on West 4 agreed with these

definitions. Those who did not particularly subscribe to a team idea of nursing, defined the ward in different terms and considered that it was possible to be therapeutic despite the above mentioned problems. As far as Nurse Mercer was concerned, there was a clear therapeutic understanding on the ward.

> On this ward - medication, chemotherapy, O.T. R.T., to a certain extent we use psychotherapy. For example if a patient has certain problems if he is say a recluse, doesn't want to talk to anyone, that's his problem. So our action is to talk to him, a maximum of a certain times a day, trying to get the patient to communicate and we try to get more information out of him and try to convince him we are trying to help and build up a relationship, a rapport, and actually we are using psychotherapy. That's what this ward is.

As will be seen in the section on nursing roles, some staff subscribed to an individual approach to patient care, while others emphasised the importance of team nursing. This was the basis for a certain amount of potential conflict in the ward situation, apparent in the nurses' statements.

East 2 had the most specific and simple definition of the therapeutic situation. As we saw earlier the head nurse had worked in similar wards for nineteen years and had quite specific expectations for the nursing staff.

> Head Nurse Trotter: The patients are all O.B.S. The majority is in the 40 to 50 range, from alcohol abuse. It is mainly a lot of physical nursing, we have to do everything for them.

Other nursing staff on East 2 agreed with this ward defintion.

> Nurse Robb: We are involved in patient care. It's quite depressing. It's irreversible. So we can only look after them until they die.
>
> Nurse Mathews: On a ward like this the most we can really do are daily chores. You get them up, dress them, just more or less complete supervision. We basically have all O.B.S. and we don't think there's much you can do with them.

There was opposition from the nursing clinicians to this purely physical nursing on East 2. Some of the nursing staff shared these views and while recognising that the dominant mode of treatment was physical, they did not agree that this was either desirable or necessary.

> Nurse McDonald: We have to be innovative and set up programmes for the patients. We assess each patient individually and set up programmes to accommodate them.
>
> Nurse Dennis: I don't think they're very flexible here. There's too much routine. They say use your discretion. For example if a patient can't go to the tuck shop and you need grounds, that has to be signed by a doctor. That's inflexibility. There aren't enough facilities for work for the patients.

> Nurse Elliot: It's helping these people to function, as best they can. It gives you a sense of satisfaction to see them do some things. There are ways of communicating with some of the patients. Like there's a patient who's blind and deaf, but two of the staff can communicate with him by touching him.

The doctor on the ward agreed with these three nurses, and this frequently resulted in conflict between him and the head nurse.

> Dr. Stone: I look at each patient, not talking of the fact that they have a chronic brain syndrome, and will probably be here for the rest of their lives, thinking of them as a person and what can be accomplished. Of course not everyone agrees. They mainly concentrate on physical nursing, but I can do more.

One Nurse 2, Meredith, while he did not agree with dominant definition of the therapeutic situation on East 2, realised that there was little he could do to change anything.

> Nurse Meredith: Now O.B.S., most of it is physical, you know, getting up, getting washed, eating and things like that. Although if you don't watch out you have everyone simply task oriented, what we call functional nursing. Although we don't agree with it, it's what we do.

West 2, surgical, as it was officially defined by the hospital administration, had the simple function of caring for post-operative patients. This was basically functional

care, as would be found on any general ward. The nursing staff, however, while agreeing that this was the main function of the ward, recognised another psychological dimension to the therapeutic situation.

> Charge Nurse Simmonds: It's not just physical, it's necessary for them to deal with the psychological aspects. It is more difficult than in general hospitals - total care of patients. For example patients will walk after they have a pin put in their hips, or they will take out catheters or I.V.'s and so I feel it is necessary for us to treat the emotional needs of the patients.
>
> Nurse Scanlon: We're kind of an oddball really this ward. It's a little more difficult dealing with patients here. You can't give an order here like in general hospitals, you can say something and repeat it ten minutes later.

The nursing staff in each ward then, recognised the existence of a ward definition of the therapeutic situation. To a large extent they agreed with it, although certain nurses expressed opposition, and a few defined it in quite different ways from the majority. What does this tell us about treatment and care in the ward situation? It is necessary to consider the nurses' role definitions and their attitudes to the patients, before we can have a clearer understanding of the prevailing ideologies on the wards.

Roles and Responsibilities

Over the past few years the psychiatric nursing role has become a much researched and debated subject, largely from the point of view of improving staff-patient relationships. (cf. John, 1961, 1961; Coe et al, 1967; Field and Pierce-Jones, 1967) My aim was to elucidate how the nursing staff actually saw their work, what they considered their roles were, and to speculate about what might have been influential in forming these ideas.

Much of the recent work has stemmed from Gilbert and Levinson's (1957) "custodial-humanitarian" dichotomy. They analysed nursing aides on the basis of their role performances, personality and ideologies and devised this continuum as a means of classification. While they were only examining aides, the same continuum can be used in considering nursing staff in general. Essentially "custodialism" is characterised by mistrust, impersonalness and perceptions of the patients as unpredictable and dangerous; mental illness is conceived of as being abnormal and hopeless. "Humanitarianism" involves optimism about the possibility of patients recovery in a therapeutic environment.

Scheff (1962) classified nursing staff as "reform", "conservative" and "neutral". The "reform" role consisted

of defences against the patients, neutral behaviour and avoidance. "Conservative" also involved neutral behaviour but was combined with discrimination and derogation of patients. The "neutral" nurses treated hospital employment as just another job.

Caine and Smail (1968) divided nurses into similar categories on the basis of their attitudes towards treatment. "Physical-impersonal" nurses emphasised avoidance and at the extreme were similar to Gilbert and Levinson's (1957) "custodial" staff. "Detached-professional" nurses saw their work as involving therapy and advice. They emphasised professionalism and did not consider that emotional involvement with the patients was desirable. Those nurses who were sympathetic to the patients and became involved in intensive interactions were classified as "protective-identifying with the patients".

To take what the nurses said and fit them into the above categories would omit a great deal of variation in personal opinion. It would be more relevant to see their views on a continuum, similar to Caine and Smail's, although as will be seen this is probably not adequate for our purposes. This is partly because most of the nurses could be placed somewhere on the continuum between physical-impersonal and detached-professional, with the large majority as professional. Very few defined their roles, or related to the

patients as "protective-identifying with the patients." This could be due to several factors. The most obvious, and probably the most important is that disillusionment may occur after some time.

> Nurse Paterson (B):[1] Most people when they first start nursing here come in with ideas about helping. When most students come in first on the wards they are humanitarian types. Then the longer they work here, the more they become institutionalised. They become tougher, maybe smarter in a way. They can tell what type of patient needs help and what type takes advantage of the situation.
>
> Nurse Walker: I worked on and off here for twenty years. It's a depressing place to work if you come to work thinking about certain psychiatric theories and thinking that you will get certain results. In essence you have a place that is treatment oriented but it doesn't work. It's sort of demoralising because there's a given set of expectations which can't be fulfilled.

Both of these nurses were males, and had had lengthy experience in psychiatric nursing. While their attitudes may reflect personal dissatisfaction, the lack of idealism among the majority of the nurses probably does substantiate their arguments. This disillusionment need not necessarily

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1. (B) denotes that the nurse was trained in Britain.

be based on the same factors as would be expected in every job. The psychiatrists did not express similar attitudes, partly because they did not define the practice of psychiatry as 'curing' and because, as a professional group, they have the emotional support of other psychiatrists and faith in their knowledge. The nurses on the other hand, did see the 'revolving door' syndrome as problematic and to a certain extent this could lead to a certain amount of the disillusionment. As Brown (1973:413) argues, "humanitarian beliefs and therapeutic pessimism can be a fatal conjuncture." To solve this dilemma, Brown (1973) further argues that nurses could attempt;

> to change the objective circumstances, to change beliefs, or to leave the job as nurse altogether. (1973:414)

In a large institutional setting, to change the objective circumstances is obviously difficult, so the most likely alternative, given the fact that the nurses I was interviewing were still employed, would be for them to have changed their beliefs. Brown considers that these changes would take the form of perceiving the patients in dehumanised terms. While some of the nurses did develop this approach, the majority seemed to have adopted a detached perspective, both in defining their roles and in their attitudes towards the patients. This perspective is exemplified in the following statement.

> Nurse Read: I'm a realist. So when someone's doing something unreal, I do something about it I'm not particularly harsh. Enough pressure can come to bear without having to retaliate. I don't really seek patients out that much. I kind of like to wait around and see what happens. Some staff act a little differently. They like to get out and rap with the patients straight away. Sometimes a patient has been in a side ward and I walk in and talk about it. I'm interested in new approaches but I throw out about 99 percent of them. I'm a bit of a Pavlovian . . . I believe that just about anyone can be cured. I think we should work from the heart. Not get emotionally involved though . . . You have to strike a balance. I try to maintain an objectivity dealing with the patients.

The majority of the male nurses tended to see their roles in similarly detached terms. They generally emphasised the advisory, as opposed to the strictly therapeutic, aspect of their work with patients.

> Nurse Selvin (B): I see my strong point as observing and I repeat and pass things on to the doctors. I don't see myself as a counsellor, you know, leading them by the hand and telling them what to do. You know I can give them a bit of encouragement, but as far as plotting their lives. Some nurses do, it depends on their personality. I've been in psych for twenty years. I am not an idealist as some, but I hope I don't sound negative. I think there's always a need for this. I think our job really consists of picking them up, dusting them off and putting them down.

> Nurse Hemmings: You know what has to be done. It's a dynamic situation. I just throw them a lot of things and they can do what they want with it. So if someone's depressed, I suggest a lot of things. You just can't give a person E.C.T. Depression arises from something. There may be a very good reason for it. I don't have any grandiose ideas about curing anyone.

> Nurse Callaghan: I guess I like it here. It's either that I'm happy with my job or I couldn't do anything else. Some people are not satisfied with what we do. They think we should be getting into more deep psychotherapy. But I don't see it that way.

The female nurses on the other hand tended to place stress on rehabilitation in terms of discharging the patients. They were more concerned to make the patients realise that their aim was to cope with the outside community.

> Nurse Green: Our job is to try to get them better see them go home and make a go of it. It can be very frustrating but that's the way it is. You just talk to them and try to get them interested in the therapies, and we use medication. Get them interested in being outside, then they get to accept that it's no bed of roses out there.

> Nurse Cameron (B): I don't agree with a lot of the treatment that's going on. All this one-to-one stuff. It may be nice for the patient and interesting for the nurses, but it's not what it's like in real life. When they go outside they find it very different. I think you should be sympathetic but make them realise just what it's like. You can't treat them as if they need pampering.

According to McGhee (1957) the female nursing role is essentially subjective, affective and spontaneous, while the male nurse is objective, rationalistic and less emotional. Gilbert and Levinson (1957) found similar differences between males and females in terms of psychiatric ideology. This may be seen as grounded in the wider society's view of the male/female role. In fact only two of the female nurses interviewed defined their roles in terms of affection or spontaneity.

> Nurse Bacon (B): I do feel a little discouraged. They gain a little independence and then you send them out into the community, then a couple of months later they come back and they are even worse. They say mental illness can't be cured. It's just palliative. It's especially sad for the younger ones. They get so institutionalised. You get so used to the patients, you present youself as a mother figure.

> Nurse Robinson: I like to get really involved, We all I guess have this idea that we can do something for them . . . One woman said to me that I'd done more for her than anyone else because I cried with her. She told me something very sad and tears, I guess I cry easy, the tears just came to my eyes and that was fantastic, but it wasn't done because I wanted to help her, it was done, because of a real emotional situation.

It would seem that the nursing role for both males and females has become professionalised in recent years, and that in their training they are taught to approach patients in a very detached manner. One male nurse,

although he had been trained at Riverview, expressed dissatisfaction with this approach and defined his role in emotional-spontaneous terms.

> Nurse Todd: Sometimes I get into trouble with the supervisors because I'm not professional enough. But what are we trying to do, brush up our professionalism or reach the patients? For example, one nurse used to have this relationship with a patient. They used to have slanging matches and the supervisor didn't like it. They were the only two who had a half decent rapport. Basically you have to remember you're not trying to change the patients' moods or anything. The minute you impose your ideas you're in trouble.

Several of the nurses on the acute wards held rather uncrystallised views of their roles, although they seemed quite willing to adapt to any situation as it arose.

> Nurse Lawless: I'll do anything I feel I do what needs to be done - talking, chatting, getting patients involved in activities.
>
> Nurse Phillips (B): I think psychiatric nursing is pretty elementary . . . There's not much you can do with manic patients, just sedate them, and discuss things with them later.
>
> Nurse Mercer (B): Well as a nurse, our main concern is to make sure the patients are getting the treatment the doctor prescribed and trying to get the patients to recover as quickly as possible. . and send them home to their old jobs and their families.

Part of the problem relating to their role definitions as non-specific, lay in the lack of time available, particularly in West 4. Several nurses expressed concern over this matter.

> Nurse Cartwright: The only thing that's unsatisfactory is the lack of time to deal with the patients.
>
> Nurse Helm: It's still pretty intensive care we have to give these people. We had a discussion the other day and the general feeling was that it had settled down a bit, most of the time. But the other day we had five admissions and so the area where we do our paper work was like Grand Central Station.
>
> Nurse Morgan: But if we're only going to have patients until they can function on an open ward, so we can't get involved in any type of intensive therapy. They get moved out. It would be different if we had them until we really understood them.
>
> Nurse Phillips (B): Possibly there are many ways of helping patients, but because of the ward structure, the routine, you find yourself stuck.

Only one nurse, a male, defined his role in the Intensive Care Unit as having nothing at all to do with psychiatry. He made this statement after the Unit had closed and he had been moved to West 2.

> Nurse Scanlon: I had a choice when I.C.U. closed to go back into psychiatry or this. But I haven't been in psychiatry for ten years so I chose this. This is the sort of thing I enjoy more although I've only observed them a little. So I can't myself play cards or pool all day anymore.

Despite the emphasis in several of the above statements concerning the fact that some nurses thought others were too much involved in intensive psychotherapy, none admitted to this when defining their own roles. Three nurses, two males and one female, did however, state that they would like to implement such treatment programmes.

> Nurse Gladwin: Right now I think the main thing in the ward is chemotherapy, which is all right but for a lot of these patients it's not enough. If patients come in really depressed, down, no self esteem and give them anti-depressants, you're still not building up their self esteem. More psychotherapy, maybe it's not in our job description, but I think it should be.
>
> Nurse Cramer (B): I guess I'm saying that it's necessary to be just as much a therapist as a nurse. I guess it depends on how much you like doing therapy. It dpends on the individual. We get a lot of patients who're not really psychotic who would really benefit from group sessions and activity. In fact I guess the majority of patients have personality problems.
>
> Nurse Nelson: I would like to get into intensive one-to-one with some of the patients, because I really don't think that some of things we do are very helpful. I don't know, perhaps I haven't been in nursing long enough.

By her own admission, Nurse Nelson recognised that it was possible that her idealism would change over time. Even if the problem of subscribing to humanitarian beliefs and

recognising therapeutic ineffectiveness does not inevitably lead to any of the alterantives previously mentioned, it would seem likely that pressure from co-workers would prevent this nurse from managing to start in depth psychotherapy with the patients. Not only were the nursing staff against this type of approach, but the psychiatrists also considered psychotherapy, if indeed they did any at all, as their domain.

Only one nurse on the acute wards defined her role and responsibilities as essentially non-psychotherapeutic.

> Nurse Benish: But I don't feel my role here is I don't think I should really get into heavy things with my patients. You know I don't think that a lot of their personal lives are any of my business and so I would rather talk to them more casually, because you know I don't think it matters whether they hate their mother or love their father or whatever. . . I don't think as such we are therapists.

As might be expected, similar attitudes were found on West 2 and East 2, which were essentially non-psychiatric wards.

> Nurse Guthrie: I enjoy working in this ward. (East 2). Physical care, we'll have the choice of staying here or moving with the ward, I'll move.

> Nurse Enders: I like this ward. (West 2). I'm really upset it's breaking up. The patients get treated the same way they would in general hospitals. I like it here. I thought some of the nurses were a real disgrace. When you come here, it's a different kettle of fish.

These were typical responses from the female nurses employed in West 2 and East 2. They preferred nursing which would be similar to that found in general hospitals. Physical nursing is less problematic to the nurses when they are in a situation of conflicting ideologies. These nurses responded by defining their roles and responsibilities in simple, clear terms and they concentrated on general physical nursing.

As was mentioned earlier, the charge nurses were in a position to define the ward therapeutic situation, and in fact they ran the wards. In general they defined their roles on the wards as leaders, administrators, consultants and overseers.

> Charge Nurse Walsh: My own philosophy with regard to patient care is a little different than some other peoples. Basically I think everyone as an individual must assume responsibility for their own behaviour. The role I see nurses performing is to provide a place and situations where people with support can try new behaviours and experiment in a very safe way . . . People do need to know what happens if they do this and I ensure that these things happen . . . part of management style really is to kind of elicit a recognition of need from the people who are involved. Kind of keep laying heavies on people like we're going to do this and we're going to do that.
>
> Charge Nurse Russell: It's mainly management. We attend charge's meetings and discuss things, and then we make sure the ward runs smoothly.

Charge Nurse Sangster saw her role as something more than administrator, and expressed concern over not having as much patient contact as she once had.

> Administration, paper work, that's not the reason I started nursing. It's a funny thing, you start out doing what you want to do and you progress and you get farther away, with no time to be with the patients, or if you are it's on a "this is the way it is" basis. If they don't need me they usually never call, (the nurses) but if they do it's usually because they're in a bind and they need some help to get out and so the way I come on is just the big nurse style and if I get some time to create relationships on my own I'm lucky. But I do try to keep my fingers in with two or three patients, especially if they're repeats, or if I've had good relationships with them before. I try to recultivate that because they're difficult, and if you've already got trust, it's a shame to lose that, especially with paranoid people.

One female Nurse 2, administrative, expressed similar concerns. She too wished to retain part of the nursing duties and responsibilities of a Nurse 1, and considered administration as only part of her role definition.

> Nurse Robinson: Now I'm an administrative assistant so my job description has changed, which means I don't have as much time with the patients, as much patient contact as I had before, and that doesn't really appeal to me all that much and yet I like the administrative duties I'm doing . . .I like to be

> part of making the system because there's a lot of things that I can change. When you're a nurse you can suggest, but now I have a little more power . . . But I miss the patient contact too. I like to get really involved. I can spend five or ten minutes with a patient now, where before I could spend an hour.

It is interesting to note that both these nurses were female. The male nurses in Nurse 2 positions, like the male charge nurses, defined their roles and responsibilities in terms of their duties, not as therapists, but as organisers.

> Nurse Meredith (B): Mainly my role as a second is to be aware of all the ward, what all the nurses are doing and in a nutshell, you try to maintain hospital policy of the standards of nursing care and make sure they do it type of thing and that's the main thing. It's maintaing the high standards of nursing care and seeing it's done correctly, without skipping and what have you.
>
> Nurse Friesen: My job is to organise nurse work load and try to match staff with patients. I evaluate staff performance. I don't give patient care as such. I find working at the administrative level much more challenging than other jobs at lower levels.

Another Nurse 2, clinical, defined his role in a similar way and in addition emphasised that his present job was only temporary until he could ascend the hierarchy into administration.

> Nurse McDonald: I have to be innovative and set up programmes for the patients. I'm the resource person on the ward. I'm supposed to set an example. I will explain to all the nurses what I expect. I don't want to remain here. I want to go into administration. Every supervisory position I apply for.

So the nurses' definitions of their roles and responsibilities would seem to be quite complex. As well as there being some differences, attitudes may depend on where and when the nurses did their training. Stotsky et al (1967:83) found that nurses' ages, in conjunction with when they did their training was important in the formation of their attitudes to treatment. Those trained before 1940 had authoritarian, socially restrictive attitudes to nursing, while those trained after this time held concepts of dynamic, community oriented psychiatry. While none of the nurses interviewed had received their training prior to 1940, it is interesting to note that the majority of nurses were therapeutically oriented to some extent. Comparisons in this case are impossible.

From these responses it would appear that age had little to do with psychiatric attitudes. Nurse Benish the most custodial and impersonal of the nurses on the acute ward had only eight years of psychiatric experience including her training and was only 27. On the other hand the most 'psychotherapeutic' nurses, possibly Gladwin and

Cramer, had had 15 and 11 years experience respectively.

Nurses' training in recent years has concentrated on psychotherapeutic aspects of nursing and this will have inevitably affected the ideas of some of the nurses interviewed. Lewis and Cleveland (1966) found that attitudes to mental illness and patients become more tolerant and less authoritarian after training. However, some of the nursing aides interviewed, who had received no training, shared quite tolerant attitudes to towards patients.

> Nurse Hemmings: I like the institution. I find that with experience I allow for more craziness. We assume that generally because a person has some crazy ideas that they can't function. But that's not always so. There are a lot of crazy people out there, it's just whether they bug other people.
>
> Nurse Moss: My main job is just being with the patients. If one of the patients is being uptight or something, we can talk to him. We have all the time to be with them. If he's had a bad day you can sit and discuss it with him.

Role theorists such as Linton (1963) have equated status position with role or the enacting of a prescribed role. Cohen and Struening (1963) similarly equated level of professional training and position in the status hierarchy of the ward to attitudes to mental illness and, in effect, to role ideology. Given the diverse views found in the wards at all levels, the situation in reality would seem much more

complicated than that. This will be examined further later in this chapter when we consider nursing work styles and attitudes towards patients in general. Many other writers have emphasised the importance of professional training in developing the nurses' conception of their roles. (cf. Caine and Smail, 1968: Etzioni, 1960; Giedt, 1957-58)

Johansson (1967:305) found that the nurses lower down the hierarchy had custodialism forced upon them. The organisation of the hospital made demands on those in different status positions, and aides had custodial duties demanded of them, so they in turn developed custodial attitudes. In Crease the extent to which the aides perceived this situation seemed to depend on their own approach to their work, and related to their past experience. For example Nurses Cameron and Bean had 20 years and 25 years respectively experience as aides and they perceived this situation as having changed over time.

> Nurse Cameron (B): What I don't like here not like home (in Britain) is the way the aides are treated differently from the nurses. At home they all did the same jobs, but here we're the ones who have all the contact with the patients and some of these nurses don't know a thing that's going on, but if they say something, their word is taken.
>
> Nurse Bean: Aides' job has pretty much changed. When I first came here we did most everything, gave injections, I don't

> think as well of this place as when I first came in. I think a lot of it's got to do with we're not as involved as we were. We all worked together and fought together. We took blood pressures and charted the patients and then someone decided that the aides shouldn't do it. I think they thought we were illiterate or something.

Nurse Aide Moss however, with five years experience perceived the situation quite differently.

> I'm not just an aide, we can sometimes deal with a patient and his problems. When a patient's upset, I have time to sit and deal with them . . .They (the nurses) listen. As far as my opinion's concerned it's as important as anyone's - the doctor's, the nurses'.

So this process would seem not to be automatic. Even if a custodial role is recognised as being what is demanded by the administration and by the other nursing staff, the aides either rejected it, or at least opposed it in terms of what they thought the situation ought to be. There is no evidence from these interviews that custodial views were adopted by the aides simply because of the responsibilities they were given. If anything, the evidence suggest the opposite of Johansson's (1967) hypothesis. The most psychotherapeutic nursing staff were lower in the hierarchy, although it could not be said that those higher were more custodial. As we have noted, their

emphases in defining their roles and responsibilities lay more in administration and organisation.

It would seem more beneficial to adopt a more dynamic view of role as process. As Caudill (1958:9) argues, the social role of the nurse is much more than a set of prescriptive behaviours and attitudes required of a person in a particular status position. I would speculate that other important factors such as role expectations of the actors, of others, individual personality, and the way the nurse comes to define his or her work may be intertwined in a dynamic interaction process. All these factors would seem to be important in the process by which the nurse arrives at a point of self perception.

What was interesting in the above nurses' statements, was their general similarity, both in the definitions of the therapeutic situations and the nurses' conceptions of their roles. The entire picture does not concur with that of Giedt (1957:58) who found only slight similarity of opinion in the wards and hypothesised that the experience of working together was not so important a factor as professional training and identification.

Caine and Smail (1968) argued that nurses' attitudes to work were determined by a complex interaction of personality and beliefs, with the biases of those responsible for their training, and the hospital ideology. To this I

would add the influence of ward ideology. It would be presumptuous to claim that this ideology exists beyond the milieu of the actual nurses in the ward context, but the charge nurses were in a position to define the therapeutic situation, and to enforce their ideas on the other nurses.

> Charge Nurse Walsh: I play a kind of very personal role. I try to brain wash them (the new nurses) into my way of thinking, before they get caught up in the whole system.
>
> Charge Nurse Russell: When a new nurse comes to the ward, we tell them our objectives and we hope they will fit into the role that I expect. We work as a community, and with the community, everything is a team.

That female nurses at least may accept the ward ideology as it is, is supported by nurses who had just started working on particular wards.

> Nurse Bacon (B): When I first came here yesterday morning (West 3), they gave me a basic outline of the ward orientation. I shall find out as I go along. You just kind of adopt the ward policy. You just fit in and follow.
>
> Nurse Morgan: It's really confused at the moment. (in West 4) . . . I don't know what's happening but I guess they'll tell me and then I can plan my work, do what has to be done.

It may be possible that the slightly different orientations of male and female nurses is based on different conceptions of their work as 'just a job' or as a career. Perhaps male nurses come into the job with preconceived ideas about what they are going to do and how they are going to put their particular psychiatric ideology into practice. Certainly if any conclusions can be drawn from the above, it would seem that males based their role definitions on ideas which are similar to those held by the psychiatrists, as detached counsellors and advisors: females on the other hand were more inclined to adopt ward policy and routine daily activities in order to run the wards smoothly, based on the processing of patients through treatment to discharging them into the community.

It has also been mentioned that there was considerable disagreement among the nurses over the merits of English versus Canadian training. It is difficult to analyse this particular phenomenon as it can be seen from the nurses' role definitions that there was no real difference in the statements of the British trained nurses compared to those of the Canadians. The basis of this problem may not lie in different attitudes to role definitions, but in factors relating to job satisfaction.

Satisfaction With Work

The idea of job satisfaction has been investigated in a large number of areas from varying theoretical perspectives, and a great deal has been written about the problem. Numerous theories have analysed the extent to which people have positive or negative feelings about different aspects of their work and how this results in job satisfaction or dissatisfaction.

Herzberg has contended that the job related factors which lead to positive or negative attitudes involve achievement, recognition, the work itself and the possibility of growth. These satisfy the "individual's need for self-actualisation in his work". (Herzberg 1959:114) On the other hand he considers that a deficiency of adequate motivators in a job does not result in overall job dissatisfaction. The lack of these factors, claims Herzberg, only leads to dissatisfaction when they fail to "meet the needs of the individual for avoiding unpleasant situations." (1959:114) Herzberg identified these needs as being supervision, administration, interpersonal relations, personal life, status, working conditions, security and salary.

All of these factors could of course be investigated in relation to our problem. Certainly job satisfaction in the case of the psychiatric nurse would seem to involve a

complicated interaction of various attitudes, and not a unidimensional measure of factors related simply to the work situation. For the nurses, the most important factors would seem to be related to the way they perceived their roles, defined the therapeutic situation, their expectations and the fulfilment of these, and how they rationalised discrepancies between expectations and the actual situation in their everyday work.

The nurses frequently complained about their work in the hospital, expressing dissatisfaction over a number of things. These attitudes to a certain extent were dependent on the nurses' role definition and the problems inherent in the wards' therapeutic definitions.

The female nurses in East 2 and West 2, as was seen in the previous section, stressed a preference for general nursing and defined their roles in those terms. The male nurses on the other hand frequently expressed dissatisfaction with the work on East 2 and West 2. They did not necessarily agree with the wards' definitions of the therapeutic situation and were reluctant to define their roles in terms of physical nursing.

> Nurse Conway: But what I don't like is the lack of responsibility. They just want bodies. They forget about you. I don't find this satisfying anyway. So I am looking around for something else. The majority of the people I speak to

> do it for the money, which is pretty poor, but think this place fosters that feeling.
>
> Nurse Elliot: I'll be staying in Crease when this ward moves. If anything I'd prefer an acute ward, it's probably more predictable. . . I can put my skills to use. Can't do that here.

The 'non-therapeutic' female nurse from West 3 expressed a preference for her past experience in a chronic ward, where physical nursing was predominant. She preferred this physical-care nursing to the responsibilities required of her in the acute wards.

> Nurse Benish: I worked in West Lawn for a long time - three and a half years. It's a long-term pre-infirmary ward and I just loved my little old men. . my function in that capacity would be to ensure that their last days were fun, and if I could keep them clean and look after their physical needs, and maybe get them to enjoy something once in a while, then I was doing a good job. . . I preferred that.

The charge nurse on West 2, as was seen earlier in the chapter saw his ward as being more than merely physical care. He also emphasised psychological aspects and was not so much dissatisfied with his work, as with the type of treatment frequently administered in his ward. In fact he considered that from his own experience, even in general nursing too little attention was paid to the patients'

psychological needs.

> Charge Nurse Simmonds: Even if it is a surgical patient, there are psychological problems, they don't deal with it too much - psychological, I think they should. I found that while I was working in V.G.H. maternity for a while, I was very disappointed. There's not much psychological approach. . . I find that most nurses are spending their time in the nursing station either doing paper work or talking to the doctors.

Another nurse in West 2 expressed dissatisfaction in terms of the type of work involved in the ward, and how it related to the rest of the Unit.

> Nurse Hadden: All we seem to get are enemas from other wards. I don't think that any other ward knows how to give them. You begin to feel a bit like a junk ward.

The male nurses seemed to have more idealistic expectations of their work. They may, when confronted with the idea that their job is a low status occupation, have emphasised 'therapeutic' activities, as opposed to physical care. Simpson and Simpson (1959:392) found that when asked about important duties, "78 percent of psychiatric attendants mentioned interaction with the patients". They speculate that this could be a way of developing satisfaction and an occupational self-image in low status occupations. It is possible that the male nurses in the

'physical' wards were doing the same.

The dissatisfaction which the male nurses felt when they could not rationalise their role as therapeutic, sometimes provoked a desire to leave the field of nursing. Other factors related to job satisfaction contributed to this.

> Charge Nurse Russell: I'm seriously thinking about leaving. Another male nurse in this ward and myself are thinking about starting a boarding home. We'll build two houses attached either side and live in. It's a serious plan. It would be nice to get away from here. There would be none of this red tape business. It's something I have to do soon. If I don't do it now, I see myself working here in another ten years, and then I'll probably never change.

> Nurse Meredith: There's coming a time, I keep looking, at this job and thinking, it's about time I got out and did something different - be a carpenter, or an electrician or something away from, you know, the tension. When I was up in West 3 if you were on afternoons it took you about three hours to unwind, especially if you were doing it properly, relating to and being involved in the groups, and trying not to be biased or show favouritism.

The problem of dealing with psychotic, repeat admission patients, combined with the knowledge that on discharge, little effective help would be given to them, was a constant matter of concern for some of the nurses. Some managed to

rationalise this, but others could not.

> Nurse Conway: I don't find this satisfying anyway, ther's no cures. I've yet to see anyone go home and never come back, ever. So I'm looking around for something else.
>
> Charge Nurse Sangster: They can be so psychotic for so long and get better and still feel that medication is no use to them, and you know the day they get discharged, they're going to walk out and toss the pills in the usual bush behind the tuck shop. You wouldn't believe the amount of medication that's been found, thrown away before they get on the bus, and you know they have no intention of taking the medication, so you know that in about three months . . . I don't know what kind of follow up you could arrange, obviously what we have isn't effective enough, and yet I know they're out there trying like mad, but you can't attend a person three times a day, and watch them take their pills, and yet that's the only thing that'll keep them out.
>
> Nurse Selvin: Another bad factor is the different doctors. So many different doctors with different ideas. The patients are getting screened out, the ones that are going to respond, and so we get the revolving door ones or the difficult ones. So many you know are going to be back, so I don't get as much satisfaction as I did.

The problem of conflicting ideologies being practiced in each ward situation was very obvious to the nurses, and led to certain difficulties. One of the responses was simply to detach, not to be innovative, and simply to carry out orders. This was one of the concerns of Nurse Meredith,

(a Nurse 2), and he was attempting to combat this.

> I like to talk to staff before, because you get staff working under fear sometimes, they're frightened they're going to get into trouble.

Coser (1963) discussed two forms of adaptation utilised by nurses in mental hospitals, "ritualism" and "retreatism". "Ritualism" involved the almost compulsive following of institutional norms and is similar to the responses described above. "Retreatism", the attempt to escape involvement in the institutions' goals or means to achieving these goals was a very rare response in Crease. Coser (1963) likely found more evidence of this because the patients in the setting she studied were chronically sick.

The situations in the acute wards posed such problems for the nurses' job satisfaction. The nurses generally defined their roles, as was seen in the previous section, largely in accordance with their stated official duties, as vaguely 'therapeutic'. Some of the nurses themselves however, had come to an understanding over time, that this role was not congruent with their responsibilities. It was recognised that the psychiatrists dealt with the individual patients and their treatment by psychotherapy or chemotherapy, depending on the psychiatrists' specific orientation. The occupational therapist dealt with the

patients as a group, tried to socialise them and understand their problems. The recreational therapist was in contact with them for another part of the day. The social worker dealt with any problems related to discharge. So by a process of elimination, this left the nurses very little real responsibility in dealing with the patients.

Hertz (1966) and Rubenstein and Lasswell (1966) discovered that the introduction of a 'therapeutic community' resulted in similar role confustion, role blurring and indecisiveness. Apart from those patients in pyjamas, the nurses saw the patients only for a small part of the day and in the evenings. This, combined with their actual role confusion, left them with little more to do than simple observing and caring for the patients. Not all the nurses recognised this or saw it as a problem. They had come to rationalise, as was seen in the previous section themselves as integral parts of the group process in treatment. It is surprising that the nurses in the acute wards did not demonstrate more job dissatisfaction. This may possibly be accounted for by the pervasiveness of the concepts of the 'team's' therapeutic efficacy, and the emphasis on the nurse as an integral part of the group.

Some nurses then, felt dissatisfaction with their work, their role expectancies and the limitations imposed upon them. Others, by a number of means, discussed above,

rationalised their role conceptions to fit what they were expected to do, or vice versa.

One factor, which only one nurse mentioned related to pay. Obviously this was either a problem of little concern, or it was one which relative to other job centred problems, was of lesser importance.

> Nurse Gladwin: I think at the moment a lot of them are a little bit dissatisfied, disillusioned, because well, we haven't had a contract since October of '75. We're negotiating right now, but I think a lot of them think it's pretty sad when we have to threaten to go on strike, before we can say "look we're looking after human beings". People are looking after farm animals in government employment, any type of employment, and are getting higher wages, better benefits and here we are looking after human beings. I think that's one thing right now that's the biggest thing affecting staff morale.

As was mentioned earlier, there was considerable argument among nurses over British versus Canadian, and practical versus theoretical training. This did not seem to be based on any difference in role definition, and yet it was a phenomenon which seemed to affect staff morale. The basis for this may lie in the fact that several of the British trained nurses frequently complained about Riverview and the treatment given to the patients. Such continual comparisons would obviously stimulate a certain amount of hostility between the two factions.

> Nurse Collins: They have more freedom there. In England we could do what we wanted, more or less. Here we have to go through a lot of steps, through the charges and the doctors.
>
> Nurse Dennis: I find public opinion is particularly bad across here. I never heard the term looney bin before. There aren't enough facilities for work for the patients. We did this long ago in England. . . There's a lot of argument between the English trained staff and the staff here.
>
> Nurse Mercer: The psychiatric approach here compared to the hospital back in England is that they're three to five years behind here. I would say so, facility wise speaking . . . they're much better off here than in England. But so far as treatment's concerned, no - it's a bit behind. Like seclusion, that stopped about five years ago in England. They removed all the padded rooms and everything.
>
> Nurse Conway: This is backward compared to England. All these locked wards and there's not enough follow up treatment.

Nurse Meredith on the other hand, held quite a different view of the situation. He considered that there was a real basis for the problem of the British trained nurses being accepted in Canada.

> I find the hospital's a lot different here. There (in Britain) it was just custodial, you don't do any nursing, but here they get a lot more theory and there's more expected of you and this is why a lot of English trained nurses have a hard time adjusting. They think there's someone looking over their

> shoulder all the time, looking at what they're doing.

Only one Canadian trained nurse actually complained about British trained nurses, and it was fairly obvious that the basis for her complaints lay not in the technical abilities of these nurses, but was a reflection of her attitude to their ethnic backgrounds.

> Head Nurse Trotter: The nurses are mostly British trained, from foreign countries. Some of them are difficult to understand. That's no problem in general hospitals, but it is here.

The other similar concern lay in the disagreement over theory versus practice in training. This did not actually affect very many of the nurses in Crease directly. The large majority had completed their training in hospital schools and not in colleges, and as a result, their training was largely practical. They did however frequently express opposition to the new nurses trained in colleges, or those students who periodically came for their six week practical experience. The majority of the Crease nurses considered newly trained nurses could not cope with practical situations when they arrived on the wards. In one conversation between the woman in charge of nurse training at B.C.I.T. and two nurses, the former emphasised that a theoretical background was important, and that learning

to deal with practical situations once they started work on the wards, was simply part of the education experience. The nurses retorted by saying that there was just not adequate time to explain things to the new arrivals. The essence of what was considered a 'good' nurse by most of the staff in Crease was exemplified in a statement by Nurse Conway.

> Psych. nurses tend to be more practical, they seem to have more common sense, I think a lot of it has to do with the practical experience. But that's another thing that's wrong. Nurses train at B.C.I.T. and they come here with no experience.

Attitudes to Patients and Work Styles

Role perception cannot be assumed to be identical to role performance. The two are the foci of separate although related investigations. Our problem is the connection between the nurses definition of their roles and their everyday work behaviour. The particular concern is the way these nurses used various techniques to reinforce or to justify their perception of their roles.

From my observations, the nursing staff generally attempted to perform their work in a way which was consistent with their stated ideological orientations. In the course

of their everyday work none of these nurses blatantly performed their duties or treated the patients in a way which was not congruent with their role perceptions. Their work styles in general were simply extensions of their ideological orientations, and reflected their stated role definitions. At the same time, the everyday practical situation where they performed their duties as nurses had obviously affected their role definitions over time. The only time that there was some discrepancy between role definition and role performance was in the case of nurses who ideologically opposed the prevailing therapeutic ideals on the wards. It seemed that pressure from the other staff tended to force these particular nurses to conform somewhat to the ward norms, although this was not a necessary consequence. These nurses' awareness of this situation was reflected in their statements concerning role perceptions, definitions of the ward therapeutic situations, and satisfaction with work. This particular process, however, did not affect all of the nurses. The following selected examples serve to illustrate the above mentioned processes.

Nurse Nelson, the one female who defined her role in psychotherapeutic terms, emphasising the need for one-to-one relationships with the patients also considered that her work style, her understanding of the patients, was more

effective than that of the other, particularly older staff.

> It's much better now. When I first came to this ward a year and a half ago, I was the only young nurse in the place. All the others were completely out of touch with reality. They didn't understand the kids they got in here. I saw someone diagnosed as schizophrenic and I knew better - that he was just high on grass.

Although she recognised the problems involved in intensive psychotherapeutic relationships with the patients, and the opposition she faced from the other staff on Ward 3, Nurse Nelson always had two or three patients to whom she devoted particular care, and spent a great deal of time with them discussing their problems. She was also involved in 'Transactional Analysis' groups with the ward social worker, and was trying to implement these ideas in her everyday work. On the other hand her ideas were grounded in what could be termed 'common sense', or at the most 'professional' level, in a type of behaviour modification. She did not subscribe to any of the 'anti-psychiatry' perspectives, and was mainly concerned to do her work as effectively as she could.

Nurses Cramer and Gladwin, the other nurses who defined their roles as psychotherapeutic, performed their everyday work in similar fashions, although they did not spend as much time and effort in dealing with individual patients.

Perhaps their experience had taught them that opposing the prevailing ideals resulted in difficulties with the other staff. It is also likely they realised that individual psychotherapy in so far as they could employ it, would not be particularly effective.

Those nurses who defined their roles in spontaneous emotional terms, generally enacted their roles in a congruent way. Nurse Robinson was talking to a patient one day in the nursing office.

> Patient: I'm really into music.
> Nurse Robinson: Well I'd like to hear you sometime, a good critic is something everyone needs.
> Patient: But you're a nurse.
> Nurse Robinson: That doesn't matter, I'm a person.

The patient then left the office after telling me about the work which he was going to apply for once he left the hospital, and saying it was "nice to meet you". Nurse Robinson, having observed this, said; "He's trying so hard to be nice and friendly." Her attitudes to the patients were generally sympathetic. She was quite exceptional in the everyday work situation in that she did not distance herself much from the patients.

> Nurse Robinson: We held a general feeling that no one is sick . . . didn't even call it mental illness . . . people are reacting to a stressful situation land that was their

> choice and their way of reacting. . . no one was sick, they showed maladaptive behaviour. . .patients began to realise that they weren't rejected they got to feel that we cared and they did care. . .it was a great feeling and they could feel that.

Nurse Bacon who defined her role similarly spent a great deal of time with the patients, although her concern was that the hospital should pay more attention to the patients' needs.

> It's a shame they don't have workshops here. Even for the young schizos to be retrained. . .they (the staff) provide for part of the needs of the patients, but you often find they complain of boredom.

She did define the patients in terms of their medical diagnoses and although she saw herself as performing a 'maternal' role, she also related to the patients qua patients.

Nurse Benish, at the other end of the continuum, who defined her work in almost 'custodial', detached-impersonal terms, also acted in accordance with her role perception. She maintained an unsympathetic attitude towards the patients. For the most part her daily duties involved her in sitting in the nursing station, drinking coffee, or doing practical work such as organising medication. She hurried around, keeping the ward tidy and organised. This kind of behaviour,

as was noted earlier, was a common way of retreating from a conflict ridden job. Indeed she considered that any interaction with the patients were undesirable in therapeutic terms.

> Nurse Benish: . . . you run the risk of increasing their dependency on the place and I mean how many of us have somebody who can spend a one-to-one type of thing with us. . . You know you may have a girl friend, boy friend, husband, wife whatever, but you don't have somebody who can be objective to spend a one-to-one with you. I mean how realistic is it?

One instructor from B.C.I.T. had visited West 3 just prior to this and had criticised the staff for not being involved with patient therapy. This was obviously one of the factors which had stimulated the above comments. In general her attitudes to the patients remained singularly unsympathetic.

> Nurse Benish: It's hard to work in this area, because a lot of my personal feelings interfere with it. Like I can't stand welfare bums, and I can't justify myself being out working and paying for a bunch of people who could work but can't be bothered. I find that really hard to handle and so I may be not as patient with them as what I could be but it's just that I . . . well after a while 'till you fire them out one door and they're back in another door.

One day on West 3 the staff and patients were preparing for the ward sale next day. I asked what was to be on sale. Nurse Benish replied:

> The patients. What else? Two for each customer. take them home - instant entertainment.

The charge nurses, while defining their roles in terms of management, were obviously obliged to deal personally with the patients in the course of their everyday work. The extent to which they did this depended on their personal orientation and on the support from the other staff. While Charge Nurse Sangster defined her role both in terms of management and in patient contact, her attitudes to and the treatment of patients, were rather more custodial and authoritarian than she admitted. She defined the patients in West 4 as:

> Really different. They're psychotic and if they're not psychotic, they're horrible. They're just really rotten. They mainly come from jails and quite a few are Form A's. One man attempted to hang himself in jail, so was sent round here quickly. Another man just flipped out in court, called the judge - you name it - and was completely incoherent, and so he was brought round here with the aid of four guards.

Her attitudes to the patients on West 4 are quite understandable but incongruent with her role definition. It

is likely that the pressures on the new West 4 changed her perspective and forced her into some actions which she would normally have been reluctant to do.

On one occasion there was an emergency on the ward and male staff from West 3 were called to help. A patient had broken a window in town and been brought in. At one point ten nurses were trying to hold him down, although he seemed quite docile. Charge Nurse Sangster had ordered an injection for this patient, who as he lay on the ground, looked up and calmly asked, "what's all this violence?"

Certainly this charge nurse was concerned to enforce strict rules for behaviour in West 4, and frequently used seclusion as punishment for infringements of the rules.

> Charge Nurse Sangster: We're using seclusion as a disciplinary sort of thing . . as a rule it works. I guess the longest or the most times we've had to deal with one guy was six times, and that was a lot of promiscuity that he was showing and some of the women we have are just so psychotic that they have no idea what they are doing or what they're letting others do to them, but we just had a temendous amount of overactivity, sexually and particularly from one guy and it took him six times to dawn on him.

The head nurse on East 2 was probably the most custodial of all the nurses in Crease. She rarely spoke to the patients, spent most of the day in the nursing office, and gave orders

to the nursing staff. Generally she ignored the patients if they passed her, or she shouted commands to them. One nursing clinician described her particular style in this way:

> Have you seen the move "One Flew Over the Cukoo's Nest?" She's just like the big nurse in that. You know at the end when the big nurse says, "you know I know your mother. I'm going to tell her about you?" Well I went to see that movie on Friday. I walked into East 2 on the Monday, and she was saying that too; "I'm going to tell your mother you know!"

Quite a few of the nurses expressed concern over the treatment of the patients in East 2; generally those who were or who had been dissatisfied with their work in that ward.

> Nurse Conway: I was in East 2 before but I didn't like it there. I didn't like the way the nurses were treated. Not that there was any physical violence, it's just that they treated the patients like animals.
>
> Nurse Guthrie: The thing that bothers me about this place is the way some of the nurses treat the patients. You wouldn't get that in general hospitals.
>
> Nurse Enders: I sometimes wonder if the patients are taken advantage of because perhaps they know that the families won't be checking up.

Charge Nurse Walsh also spent little time with the patients. His work centred around planning programmes and organising and supervising patients' treatment. He thus performed his work exactly as he had defined his role. He was concerned to change the therapeutic environment as he considered the patients were too dependent on the hospital.

> The great traditional stories that mental hospitals are horrible places and that everyone wants out are just not really accurate. We create an environment that people learn to need - too much give and not enough - there's no investment on the part of the patients to gain. There's two dances a week and one movie a week . . . That's a very destructive process. However, if you look at these things I think would be most meaningful, it's really difficult to involve these techniques that requre a great deal of staffing, a great deal of time, and a great deal of ability.

He was obviously dissatisfied with the extent to which he could implement treatment programmes and function effectively in his nursing role as he wished to do. In fact, he left Crease two months after this interview, and took a position in Community Health.

Charge Nurse Russell, on the other hand had a very uncrystallised view of his role and the definitions of West 3's therapeutic situation. He spent as much time as possible

with the patients, and joked with them frequently. His approach to the patients was generally not authoritarian and he seemed to find amusement in the most common everyday occurrences.

One patient came into West 3's nursing office complaining that a nurse was not giving her the injection in her buttocks in the proper way. The doctor was eventually called upon to perform this duty.

> Patient: I want to see it. I always look. . . She (a nurse) won't give me it another side. She's trying to do it in the back. I want the doctor to do it, not her.
> Charge Nurse Russell: She's got her own way now. She always does. (He laughs).

On another occasion a patient came to the nurses and asked for his clothes. "I want to go to the boudoir, I need my things." Everyone laughed at this grandiose description of the ward dormitory. The charge nurse repeated, "the boudoir!"

One other conversation took place between Charge Nurse Russell and the social worker, concerning a patient who had expressed discontent with the morning's Transactional Analysis group meeting.

> Social Worker: He wasn't happy with the group this morning. He doesn't want to continue. That's a pity because

> he was really getting support from the group. We were giving him strokes, I really think we should force him to continue . . . Not that we can force him really.
> Charge Nurse Russell: We could bribe him!

In general, Charge Nurse Russell's work style was considerably less structured, less goal oriented, than those of the other charges. In summary, the ward definition of the therapeutic situation was similarly lacking in order and direction, and the nurses' role definitions were quite varied. The ward seemed to function quite adequately on a day to day basis, however when a crisis occurred the lack of direction seemed to be a disadvantage. One patient who had attempted suicide outside, had been brought into West 3. He tried again by drinking a bottle of "Selsun", having warned the staff that he was going to do this. The subsequent chaos was obvious. No one knew what to do or who to tell. In the midst of the chaos the patient was left alone and he proceeded to try to hang himself. He was saved by another patient who had observed his actions. In the aftermath the staff, lacking external control and direction, did not meet to discuss the matter or how to deal with such occurrences in the future. Instead each individual denied personal blame, and concentrated his efforts on questioning and blaming others.

The majority of nurses, in so far as role performances were concerned, acted congruently with their role definitions, although in general there was a certain amount of ambivalence in both the particular interviews and in the everyday work styles. Most carried out their duties in a detached fashion. They spoke to the patients when necessary, but otherwise they spent most of their time dealing with paper work, attending ward rounds, or talking to each other. Nurse Read for example, who emphasised the point that he waited for patients to come to him for advice, did exactly this. He saw himself as part of a team, and as such, worked in conjunction with the other nurses.

> Nurse Read: If a decision is made, we stick by it. That's really good. You have no problems. Very few patient fights. Then if a patient is out of line, he has to deal with the whole team, not just one individual.

Most of the nurses held quite sympathetic attitudes towards the patients, even though they remained professionally detached. They expressed concern that nothing was being done for the patients and that the community outside did not support them.

> Nurse Dennis: A charge nurse once gave me a piece of advice - treat them like human beings and they'll act like human

beings. You'll have no problems.

Nurse Gladwin: It's amazing if you take a look in the day room on an afternoon, the waste of humanity out there, just doing nothing.

Nurse Elliot: The problem with the Patients' Bill of Rights is that the people who made it up are the very same people who would object most strongly to having these people in the community beside them.

Nurse Selvin, who defined his role similarly to Nurse Read and to many of the other nurses, also acted in a very detached way in interaction with the patients. Nurse Selvin did however recognise that in West 4, part of the problem in dealing effectively with the patients arose from the types being admitted. Sometimes it was not possible for him to remain as detached as he said, and he adopted a more disciplinary approach.

Nurse Selvin: We feel that a lot of the patients we get should be either in jail or down at Riverside. They do something under the law and the police seem to charge them under the Mental Health Act, maybe just to get them out of their hair. . . A locked ward sometimes aggravates some of the patients. But others seem to be more secure when there are controls on them. Maybe we do control behaviour, and violate their rights, but if we didn't we'd feel frustrated and some of them are like kids, testing us to see how much they can get away with.

This was a problem faced by most of the nurses particularly in the acute wards. While most of the nurses discussed earlier in this chapter attempted to enact their roles as they defined them, they frequently found themselves in a position of having to give orders to the patients. Also, because of the problems and pressures inherent in any psychiatric ward, all of these nurses frequently deliberately avoided interaction with the patients. This could be done by concentrating on paper work, or by discussing 'private matters' with the other nurses in the nursing office. This was obviously easier for the Nurse 2's, for whom administrative work, and planning was part of their official job description, but the Nurse 1's also frequently adopted such evasive strategies. That is not to say that these nurses were therapeutically ineffective, or just 'bad' nurses who derived no satisfaction from their work. Indeed it was fairly clear that the majority of the nursing staff, particularly those on the acute wards, saw their work as important and defined themselves as professionals.

It is quite understandable that dealing with certain people, that is the patients, who normally do not know the appropriate rules for interaction, or who continually violate them, poses problems for all nursing staff, indeed for all people who come in contact with them. Essentially it is just too difficult or exhausting constantly to engage

in interaction with people who do not act in accordance with the everyday normal rules. Goffman (1963:62) gives the example of children and patients who play the game of "attack the encounter", that is they sometimes move into a conversation between people, frequently too close for comfort. The response of most of the nurses in such a situation was to back away and avoid all physical contact with patients. In a limited area, if a nurse wanted to pass a patient, he or she would usually speak or shout to the patient to move.

The most obvious solution to this dilemma was for the nurses to detach themselves from the patients, not so much in terms of removing themselves physically, but rather to try to deal with the patients as the psychiatrists would. There were various techniques which the nurses commonly used in maintaining and defining their status as nurses, and so distinct from and even superior to the patients. Traditionally the nurse wore a uniform which visibly separated him or her from the patients. Several studies have investigated the effect of wearing or not wearing uniform on staff-patient attitudes and interaction. (cf. Larson and Ellsworth, 1962; Jones et al, 1964; Brown and Goldstein, 1967-68) With recent 'humanitarian' approached in psychiatry, this has generally been abandoned in most mental hospitals. The only nurses wearing uniforms in

Crease were the head nurse in East 2 and the staff of West 2, surgical.

The uniform is not the only symbol which defines the nurses' status as superior to the patients. The most obvious substitute for the uniform was a bunch of keys. Sommer (1969: 331) agrees that the possession of keys is a mark of status in a mental hospital. The nurses usually carried these in an obvious place, such as attached to their belts. Alternatively, when moving about the hospital they would carry them in their hands, making a noise, so anyone encountering them in the corridors would instantly recognise them as staff, and not as a patient. Carrying files or pieces of paper served a similar function. One other interesting aspect of behaviour was the manner in which the various persons walked around the hospital. The nurses generally walked very quickly, conveying some sense of immediate purpose to the audience, while the patients were distinguished by their slow ambling pace. This was probably partly a result of the medication and partly because of the simple lack of anything to do. Surprisingly, the doctors also walked very slowly, presumably because they felt no need to enhance their status in the view of any audience.

More subtle methods also demonstrated the nurses' status relative to the patients, although these were not always consciously used for this purpose. They had 'territories' on

the wards, the most important being the nursing office. This was the domain of the nurse, and any patient in the office was there by permission of the staff. The nurse had only to retreat to the office to demonstrate that he or she was not a patient.

Another use of space in the ward was relevant to this problem, if we consider Hall's (1974:206) ideas on proxemics, "the study of man's perception and use of space". He discusses the crucial spatial cues in conversation, the "flow and shift" between people as they interact. There are accepted distances for social conversation, although these probably depend on the definition of the situation and the roles, attitudes and personalities of the actors. Goffman (1963:33) too, in discussing non-verbal communication, admits that such factors as physical appearance, movement and position, while not adequate to convey actual messages, do indicate the actor's social attributes, his concepts of himself and of the others present. What is important in the case of nurse-patient interaction is the way the norms of social distance were continually violated. Nurses in interaction with the patients usually stood outside the "normal conversational distance." (Hall 1974:207) They demonstrated their superior status by shouting to the patients across this space. Another common aspect of interaction was sitting in a higher seat than the patient, or

behind a desk, or standing over a seated patient when giving commands.

Nurses also generally avoided referring to patients as abnormal or as normal. Quite frequently in ward rounds, when a patient was being discussed, his behaviour was described simply as either "appropriate" or "inappropriate". Nurses continually redefined and interpreted each aspect of the patients' behaviour as reflecting their illness. Rosenhan (1973:253) similarly found that nurses frequently interpreted all patients' actions as symptomatic of their diagnosed illness. As Goffman (1961:146) argues, while most of the information in case notes is accurate, anyone's life could be interpreted in the same way. Some of the nurses recognised this. They were not always unaware of the interaction processes in the ward situation.

> Nurse Selvin: We all have our funny ideas, our fantasies and so on, but it's when one person starts to act these out or talk about them that society decides that something should be done. In an institution any eccentric behaviour is noted, but on the street a lot of it is tolerated or ignored.

Nurses' role performances then, were usually congruent with their attitudes to the patients and with their role ideologies. In general, all these were surprisingly similar, with slight variation among individuals. A few

nurses, as we have seen, were noticeably different, but these were exceptions. According to Gilbert and Levinson (1957) staff role performance arises partly from ideology which in turn stems partly from personality. Personality differences then could account for the slight differences among the nurses in their everyday actions and attitudes to the patients. It is possible that the dominant ward ideology was modified by the individual's personality in the process of adapting and developing work styles and that the results of this are apparent in the everyday life on the ward. Nevertheless regardless of their therapeutic orientations or role ideologies, all the nurses could be observed to act in the ways discussed above, in an attempt to define themselves as nurses, as opposed to patients, and thereby enhancing their status and their role definition.

Chapter VI

THE NURSES PERSPECTIVES ON THE INSTITUTION

Attitudes to Change

Most of the recent literature on psychiatric hospitals has discussed institutional change. This emphasis is partly a result of the many attempts to turn such hospitals from custodial asylums to demoncratic therapeutic communities. For example Stanton and Schwartz (1954) in an analysis of the hospital organisation, examined the therapeutic changes as they were implemented in a particular situation and the impact of these changes on all the staff members and patients. Stotland and Kobler (1965) examined the growth of a psychiatric hospital and staff involvement in the implementation of its goals. This study was basically a history and analysis of the various external and internal forces influencing the development of the hospital. Similarly Schulman (1969) studied the

impact of strucutral innovation and its impact on organisational effectiveness.

Riverview Hospital was in a very different position from those institutions usually described, in that as has been demonstrated throughout this thesis, almost the opposite process was being implemented. Riverview was being redefined as a long stay hospital or a secondary referral unit. Even Crease Clinic which was to become entirely 'admitting,' was receiving an increasing number of chronic patients and therefore it was not exactly amenable to attempts to design therapeutic communities even within the ward structure.

Staff perceptions of change have also been fairly well documented in the literature, but again the focus has usually been the movement toward more democratic and therapeutic hospitals. This literature usually stresses staff resistance to change, and the techniques they employ to retain something of the status quo. Scheff (1960:11-12) for example found in the hospital he studied that where the goal was to overthrow a custodial system, the staff resisted the new programme and the goals were transformed as they were put into effect. He concluded from this study that;

> . . . the resistance of the ward staff can be explained not in terms of the individual inclinations of the staff members, but in terms of the systems

> of control which operate to bring about conformity to traditional staff roles. The principle elements in this system of control were the operation of sanctions through staff leadership, and informal censure by the other staff, and rationalisations which establish a frame of reference in which reform seems unthinkable. (1960:165)

From the staff's comments in Chapter II it seemed that change of the sort that was being proposed was a constant part of life in the psychiatric hospital. There seemed to exist a myth that some kind of revolutionary change was always impending, and yet the staff did not believe that this would ever occur. In particular those nurses who had worked in the hospital for a long time had come to perceive the myth of radical change as part of institutional life. This process is adequately explained by Caudill (1958:340)

> One of the reasons for the failure of (such) attempts at improvement is that they usually are constructed as additions to the content of the over-all programmes of the hospital, while carefully staying within the already existing form of the hospital.

The problem in Crease was complicated by the fact that the situation was not simply a matter of implementing new treatment programmes and trying to encourage staff to adapt to new ways. The central concern of the staff was the

uncertainty related to the changes, and it was this which was a constant preoccupation for them. They showed no indication to oppose the changes or redefine the goals to suit their own ends. It seemed simply to be a matter of general uncertainty about the future. This uncertainty was magnified by the constant rumours which pervaded the hospital, and the lack of clear information regarding the future. Essentially it was the result of a lack of information and it contributed to an already confusing situation. It was not that the changes were undesired by the majority of the staff, although as we saw in Chapter V some nurses considered the developing situation as problematic. In general their complaints related to the ways in which these changes were being implemented. As Caudill (1958:340) argues:

> On the whole, the specific therapeutic techniques and the details of administrative proceedures in a hospital are often satisfactory enough, but the way in which these are integrated into a system, and the manner in which responsibility for them is delegated, is most unsatisfactory.

Most of the nurses' complaints related to the uncertainty which was perceived to exist throughout that year (1976-1977). These complaints arose sequentially as particular wards were threatened with reorganisation. The first people to complain about this situation were those in the

Operating Room. By the summer of 1976, they were threatened with being moved. Various rumours suggested that the Operating Room might be closed and this gave rise to a great deal of anxiety.

> Nurse Frank: The way they have treated us in this department is appalling. We just don't know, we can't try and arrange anything with our families. They should have interviewed all the staff here and said what the alternatives were. The rumours run rampant and the only answer is to give us definite answers. It's when you're faced with not knowing what you're going to move into.
>
> Nurse Walker: For the last two or three years there's been talk over the O. R. closing. I know that if there's some definite plans about the place closing they really should tell us. One day you hear something from the cleaners and the next day something from the doctors. It's not as if we're going to be out of a job.
>
> Nurse Kaiser: All we know is that they're going to change the O. R. There's no question of losing our jobs. It's just a matter of where we're moving. It's all being done in a very confused manner. There's a lot of stress involved.

It is possible that anxiety stemmed simply from the confusion that is implied in the above statements and not from any opposition to changes, opposition which did not seem to exist anyway. As Greenblatt et al (1971:6) argue;

> Generally most of the resistance against change bears little relationship to the soundness of the change advocated, but relates instead to the types of anxieties that change as such produces.

West 4 was the next ward to suffer from fears of impending reorganisation. It was around West 4 that the proposed changes were based and dissatisfaction in this ward was to be found on two levels. First the nurses considered that the ward was in a state of total chaos, and this perception seemed to be a realistic view. Second they claimed that the chaos and uncertainty affected patient care.

> Nurse Lang: It's really bad in here just now. All these changes are worrying the patients. They're all high. They've just been told they're moving, no warning. It's very unsettling for them. But that's typical, the staff get treated the same way.
>
> Charge Nurse Sangster: It's hard to look at the change right now when you're in it. You can't sort of be objective . . . No matter how you move the patients they still feel the strange environment and anxiety and it was an open ward on East 4, and an open ward here, and you come over and wander around and I think some of them did, but still I think it was the effect of coming from an open ward to a locked.

Other staff members on West 4 were more concerned with the changes which directly affected their work. Certainly

part of the role confusion and uncertainty on the part of these nurses as they described their work in Chapter V related to the reorganisation.

> Nurse Morgan: It's really confused at the moment, nobody knows what the other person is doing. Being so confused is very confusing it's very frustrating. It's frustrating for patients and staff. I find that nobody really knows what the function of this ward is supposed to be. It's active in that there's plenty going on. But the confusion is unbelievable. It frustrates rather than limits. It's just difficult to get any continuity in the treatment of patients.

> Nurse Gladwin: The staff are tired, they're frustrated to . . . we've had to consider Intensive Care and we had to consider the West 4 sort of intermediate term people. So there are other facets that we've had to incorporate. Things happen, like well for example today there was going to be E. C. T., there is no E. C. T. staff on. There wasn't anyone on duty that was familiar with setting up E. C. T. Now the East 4 people have always sent their patients over here for E. C. T. and we've helped with it, but no one here could set it up, say know what the anaesthetist wants and saying doctor so and so likes this or that.

The ward to be least affected by the reorganisation was West 3. There were very few comments from the nurses to the effect that the changes disrupted their work. Charge Nurse Russell was the only staff member there who emphasised similar problems to those mentioned above and he did consider

that the other nurses were affected.

> I'm getting a lot of questions about the changes from the staff . . . I can really notice the anxiety in the staff. I'm sure it affects performance. It's died out a bit now. When they closed East 3 that definitely worried staff and performance was bad. It looks as if we will have some changes. The latest rumours are in our favour. But you never know what's going to happen tomorrow. This place needs shaking up. Changes will be made as a result of the conference.

The administration and lack of communication within the system relating to the hospital reorganisation, was the main concern of West 3's staff, as will be seen in the next section, although very few complained about the changes as such. This was not solely West 3's preoccupation. The uncertainty brought about by the changes was blamed on the lack of communication, by all the nursing staff in Crease Clinic.

Nurse Robinson on West 3 had different perspective on institutional change. She did not see that it affected her work or the functioning of the ward, but she did consider that it was a regressive step in the history of the hospital.

> Nurse Robinson: The place doesn't really change. They make changes but they're changes that've been made before.

> The change we're making now . . . it was in effect when I started here . . . well similar . . . All admitting came to Crease and the big buildings are up the hill like they used to be. That's what we got rid of . . . The ideas of going up the hill . . . I think the changes it's making right now are backward right now. . . I think Crease at one time was considered the health spa of the lower mainland . . . the maximum stay was for four months and either you made it in four months and went home or you went up the hill and right now we have no limit on length of stay. But everything else is the same. I don't see it as a good step.

The decision to move East 2 had been emphasised at the conference with the proposal to open up an entire unit for organic brain syndrome patients. It was obvious to all concerned that the ward was to be moved in the near future. Nevertheless the nurses accepted this with fewer protests than the staff on the other wards, although they did suggest that the uncertainty affected patient care.

> Head Nurse Trotter: I don't know about these changes. The last time we got one day's notice. They didn't even ask us. But at the moment we just don't know. We can't do anything. Like this morning the nurse said we need a fan in the bathroom. I said there was no point we'd just be moving. It's a real threat to a lot of people. You know if they're climbing up the ladder. Not me, I'm retiring in a couple of years.
>
> Nurse Mathews: At the moment I'd say that everyone's just waiting for someone

> to make a mistake and I can't work in that situation. It wasn't like that all the time. Basically you're unhappy anyway and so if you have to deal with the patients it's difficult. You end up dealing with the basic needs and not the emotional problems.

The uncertainty on West 2 was most apparent. Throughout the year they were given several dates on which they were to move. Each of these was postponed, which only contributed to anxiety on the wards.

> Charge Nurse Simmonds: Well I found out first back four or five months ago that we were moving . . . and of course there was a lot of discussion going on, and then for a few months, and then they came to no conclusion at all . . . later the administration decided that we should move, that was December 9th, and then they changed their minds. . .and they set a date for January 10th. . . and then nothing was done about it until past Christmas. . . We didn't get the final word about North Lawn until two days ago and yet they are just painting and maybe won't be finished with all these things for two weeks but regardless we are moving in. . . no one asks us if that suits us, if the facilities are good enough. It doesn't really bother me but when it affects the patients, that's when it's bad.

One nurse on West 2 expressed total disillusionment as a result of the change and the constantly deferred dates.

> Nurse Hadden: I don't even believe that we're moving now. We've had so many dates. It doesn't much take you-

> by surprise. This place doesn't make sense. It's the administration. It'll be haphazard. When they say something you do it. They'll give you a rough time.

Psychiatric hospital reorganisation does not necessarily involve radical modifications in treatment programmes or therapeutic ideologies. The changes introduced in this situation were based on redefining Crease Clinic and mainly consisted of moving wards. The only exceptions to this was the redesigning of West 4 into a locked emergency ward, and the possibility that the Operating Room would be closed. The nurses did not oppose or obstruct these changes but considered that the main problem lay in the way which these were implemented. This attitude was based on the uncertainty inherent in the situation and which gave rise to a great deal of anxiety and tension. The nurses claimed that this in turn affected their capacity to carry out their duties effectively.

Perceptions of the Administration

The nursing staff in Crease Clinic considered that one of the major dilemmas in the daily life of the hospital related to ongoing changes, or the likelihood of change. The main problem appeared to lie in their lack of knowledge and

the associated anxiety. This was based on lack of communication communication or contradictory communications, which they receive from superiors in the hospital authority structure. Essentially information flow within the Clinic appeared to be rare, contradictory and downwards in direction. This resulted in adverse opinions of the administrative staff on the part of the nurses.

> Nurse Mercer: I feel that what makes everything behind is the administration. They are still running the hospital like way back and so many things you want to get done but you have to go through all the proper channels, paper and more paper and it goes up and it takes a while to get anything done.
>
> Nurse Conway: I mean this place had really been going on like this for years. You know I'd really like if we could talk to the higher ups. There's no communicating.
>
> Nurse Frank: The communications are appalling. I guess it's the same in any institution. There seems to be too many levels of authority. By the time anything gets to the top it's lost its punch. If there was more communication they could sort out a lot of problems and save a lot of money. After all these years you'd think there would be some effective way of running the place.

The nurses generally considered that the administration was in a position to improve communications and that they were not responding to the staff's needs. These nurses saw those in authority as detached from the functioning of the

Unit.

> Nurse Purves: I don't think it's fair that we are left dangling . . . of course it's very bad for staff morale . . . it's about like the old days in nursing when you were expected to do what they told you and your off duty time is not really your own, it's the hospital's.
>
> Nurse Pilling: I don't know about the administration. They may not know anything definite, but I think they're being a bit unfair. . . Communications are absolutely terrible. I do think that common courtesy would lead them to at least keep us informed.

The nursing staff considered that the administration had designed plans and were putting them into effect without consulting them. Information, as perceived by the nurses, moved in a downwards direction. They felt that it was futile to attempt to communicate their ideas back to the administration. This perception of a detached, unresponsive and unified administration structure was fairly common.

> Charge Nurse Simmonds: They did ask me, quite a lot, but I remember two weeks ago when I was asked to go up and look at that new area and I asked is there any point in me going to look or has the decision already been made? So they said well go ahead and look anyway. . . It seems to me that up in the hierarchy they don't have very much idea about what's going on. . .

> There are a lot of questions to be asked. For example how often does the administration go round the wards?

Similarly the administration was frequently seen as an entity which would punish anyone questioning its authority, or criticising the hospital.

> Nurse Benish: You know like towards the administration. If we speak out about something, you know that if you feel very strongly about or disagree with, that you know they will get in one way or another.

Greenblatt et al (1971) in examing the reconstruction of a similar institution found that similar opinions pervaded, but that it was possible to counteract them. They considered that;

> One important lesson learned was that opening communication often lessens the polarities between individuals and departments and reveals that members of a particular group are not necessarily all of one mind about controversial matters. (1971:12)

The administration itself was not unresponsive to such problems. The Executive Director, in particular, was concerned to improve communication within the Clinic. His success however was questioned by the nurses.

> Nurse Pringle: The biggest problem is the lack of communication. They (the administrators) talk about the lack of communication on one hand and then they keep secretive.

Information flow within the institution was an interesting phenomenon. It was a common belief, perhaps grounded in some truth, that the housekeeping staff had knowledge of everything happening in the hospital. This informal method of communication was said to work effectively because the cleaning staff were in daily contact with more personnel than any other type of employee. Information seemed to flow, according to this 'myth', from the administrators down to the housekeeping staff and then back to the wards. It was even jokingly said that the housekeepers made the decisions. In an effort to improve this information flow the Executive Director had tried to introduce more formal and open lines of communication. He had also stressed an 'open door' policy whereby all hospital personnel could discuss problems with him directly. On his own admission this did not appear to function even as well as the earlier closed system with its 'underground' communication lines.

One of the pervasive aspects of life in the Clinic was the multitude of complaints concerning the lack of communication, seemingly arbitrary decisions, uncertainty and

an unresponsive administration. While these are phenomena to be found in the attitudes of staff in any large institution, they were intensified in Crease during that year of reorganisation and change. This situation was a problem for the nurses in that it only contributed to already existing uncertainty and to job dissatisfaction.

Attitudes to Psychiatrists

While the psychiatrists and nurses were all concerned with the treatment and care of patients, and the nurses were in daily contact with the patients, the psychiatrists were in ultimate command. The definition of this situation was regarded differently by all the therapeutic participants; the central question being "who is the most important and effective therapist?" The division of labour on the wards was of central concern to the nurses. As mentioned previously the nurses were in a difficult position in defining and isolating the content of their work. Despite this, many of them defined their nursing roles as 'therapeutic'. The psychiatrists, on the other hand, held quite specific views on the roles and responsibilities of the nurses. This resulted in a situation where psychiatrists and nurses were competing in a way for certain responsibilities, although this was not

necessarily recognised by the psychiatrists. The nurses, unless they had come to define their work simply as custodial, or as largely paper work, were involved in an ongoing dilemma in isolating their responsibilities from those of the psychiatrists. This was a situation laden with potential conflict.

The psychiatrists all agreed that, when a patient was admitted to the acute wards they made the initial diagnosis and planned treatment.

> Dr. Treadwell: What happens is a patient comes in and you see them and take a full history and then you go on and present the patient to the nursing staff. There's a bit of a discussion and there is a plan formulated about which aspects should be stressed.

This definition was generally accepted by all the nursing staff. Diagnosis was obviously to work of the psychiatrists as doctors, who had legal and basic medical responsibility for the patients, but the actual everyday treatment situation was not so clearly defined. Each individual psychiatrists and nurse had specific ideas relating to each other's roles. These defintions and expectations were not always identical. Dr. Langton described the nurse's role as;

> supportive therapy. They (the nurses) of course look after the day to day needs of the patients and that would be physical care as well as emotional. The nurses would sit down and talk with the patients and maybe find out something the patient's forgotten or didn't want to discuss with the doctors and this comes back to the doctors and we all discuss it. The nurses, mainly supportive therapy, nothing too deep.

The majority of nurses did define their roles in this way. Those nurses who based their ideas on a 'team' approach to patient treatment and care, perceived themselves as important elements in the 'team' and frequently considered that the psychiatrists were the most important therapists.

> Charge Nurse Sangster: They (the psychiatrists) treat the patients immediately. They interview them separately. That's their job, on the one-to-one basis. Frequently they'll ask one of us along if we're interested, but it's not set up like that. They're responsible for the basic care. We report any different kinds of behaviour to them, anything we may observe.

Nevertheless, as indicated above, many of the nurses, even those defining the situation in accordance with the above statement, regarded their primary role as 'therapeutic', albeit in a rather ambivalent and non-specific way. Even among the majority of nurses who defined the psychiatrists as the primary therapists, there was a wide range of opinions. At one extreme were those nurses who accepted

that their main function was to carry out the psychiatrists' orders.

> Nurse Benish: But I think that before there's anything that we nurses can do about it, the medical profession has to really get in there and sock it to them with medications, to get them so they are accessible to us, but so often they aren't. I mean there's no way I can convince Jim (a patient) that he is not an architect nor would he believe that he didn't own a ranch and wasn't a movie star.
>
> Nurse Bacon: The nurse is always with the patient. The psychiatrists deal with the illness, therapy, while the nurse deals with the patient's basic needs.

Very few of the nurses isolated their own roles from those of the psychiatrists in this way. Charge Nurse Walsh had managed to define the division of labour quite differently. In the last chapter we saw that he saw his role as managerial and the roles of the other nurses on his ward as 'psychotherapeutic'. At the same time he relegated the responsibilities of simply providing chemotherapy to the psychiatrists, although it was obvious that the psychiatrists did not define their roles in this way. While the psychiatrists were not specifically discussing West 4 as it was when Charge Nurse Walsh was running it, they had been working on that ward at that time, and, as it was defined as an acute ward with similar patients to those on

West 3 later, there is no reason to assume that the psychiatrists themselves had changed their perspectives drastically.

> Charge Nurse Walsh: The psychiatrists work mainly from the medical point of view. They use the medical model for treatment. None of them practice psychotherapy. They use medications, they establish levels. I can't think of anything else they do. They have a legal and meaningful responsibility. A number of things require doctors' orders. For example a nurse cannot allow a patient grounds privileges until the doctor has ordered it.

The majority of nurses, however, stressed the ideas of the 'team' approach and considered that co-operation among the therapists was both the most effective method and that which was practiced.

> Nurse Read: I respect the psychiatrists although sometimes I don't agree. They usually are open to criticism.
>
> Nurse Robinson: That's another thing. . . is a feeling of one. I'm as good as you are and you're as good as I am. We're just people. That makes us equal. I used to put doctors higher up and patients a bit below, but no way now.
>
> Charge Nurse Russell: As for psychiatrists, we let them come in every once in a while to make them feel good. (He laughs). We've come a long way. They really make decisions without consulting us. We're at the point now where we can criticise and give ideas. They have to realise that nurses are the largest group and collectively we have more say.

In Chapter IV we saw that these perspectives were not necessarily adhered to by the psychiatrists. Democratic sharing of ward responsibilities, particularly in connection with psychotherapy, was not the dominant therapeutic definition on the part of the psychiatrists. These contradictory interpretations only served to contribute to the nurses' uncertainty regarding their roles and responsibilities.

> Nurse Gladwin: Well when the doctor writes down an order, that's your duty to do it, you've got to do as he says. All of the doctors are open to suggestion though. Plus the doctor when he picks up the chart, the first thing he says is what can you tell me about so and so, because I mean we're the one's working with them.

This emphasis on the fact that the nurses spent considerably more time with the patients than did the psychiatrists, was fairly frequent in the interviews and in everyday discussions. When they considered their roles and responsibilities in relation to those of the psychiatrists, a few nurses even claimed that their own practical knowledge and abilities were superior to those of the psychiatrists. Rubenstein and Lasswell (1966:72) reported similar situations where the nursing staff for the similar reasons considered that the psychiatrists had only a partial picture of the patients.

> Nurse Conway: I don't think the doctors ask your opinion enough. Maybe they listen to the charges, I don't know. But they don't ask us. They'll maybe say, "how's his foot doing?" But they don't ask us what we think or anything about his medication.
>
> Nurse Cramer: Well we know the patients, how they're doing and that. But the doctors only sometimes come here, so they don't know.

Nurse Lang was particularly critical of the psychiatrists in this respect.

> Psychiatrists are the worst. They have to be so arrogant and they can't relate to people. I don't like all that pussyfooting around. The doctors sometimes don't come straight with you. I don't like that.

The nurses, other than those who specifically defined their work in impersonal-detached terms, were in a dilemma, which rendered it both difficult for them to put into practice their 'therapeutic' roles and to make decisions regarding patients. The nurses frequently competed with the psychiatrists for ward responsibilities. This competition combined with the variety of expectations rarely led to confrontation. Apparently the nurses had developed several techniques to deal with this situation, these techniques being frequently employed in ward rounds.

Nurses and Relative Deprivation

The nurses as we saw in the previous chapter frequently enhanced their status in the everyday interaction situation relative to the patients. In contact with the psychiatrists the nurses felt themselves to be in a particularly vulnerable situation. Actual conflict between the psychiatrists very rarely arose because of the adaptation of the work processes over time.

The nurses had developed certain processes and situations, channelling thse to suit their own perspectives, while simultaneously enhancing their status in relation to the psychiatrists.

In considering their roles as almost psychotherapeutic, and in estimating their understanding of the patients as important as that of the psychiatrists, the nurses often tried to impose their ideas on the psychiatrists.

The interaction described below which took place at ward rounds is an example of a situation in which the nursing staff wished electroconvulsive treatment to be given to a particular patient while the psychiatrist did not. At this meeting in West 3 there was Dr. James, two nurses, a social worker and an occupational therapist. They were all discussing a patient who was described by one of the nurses as "a bit withdrawn." The other nurse

suggested that they try electroconvulsive therapy. Dr. James reply was; "No, I haven't used it for a while. I don't like to." The charge nurse then replied; "What are you trying to do, set a world record?" The other nurse then said' "Might as well try if all else fails!" Pressure was then put on the psychiatrists from the other staff members present, by way of similar comments and eventually he agreed that he might recommend electroconvulsive therapy.

On another occasion a similar situation arose. This time Nurse Nelson was concerned to detain a patient in the hospital because of his general non-compliance on the ward.

> Dr. Langton: He's very religious. He thinks he has a pipeline to God. Should we let him out for the weekend?
> Nurse Nelson: No, he should earn it. He should at least dress normally.
> Dr. Langton: Well maybe that's his normality.
> Nurse Nelson: It's not ours, it's not society's.

On one occasion at ward rounds, Dr. Treadwell was determined to justify a patient's behaviour to the nurses. He started by discussing the patient's diagnosis and other factors relating to his illness. He excused the patient's behaviour to the nurses by saying; "He's bored and he has no future." The nurses said nothing but looked disapproving. Dr. Treadwell turned to me and shrugged; "Well

you know we don't ever do any curing in psychiatry!" He then asked the charge nurse; "Is this man bored to death with the facilities in the hospital?" The charge replied; "But he can't be, he's had lots of opportunities." Another nurse continued; "Yes he's grandiose - all his painting." Dr. Treadwell concluded with a joke in an attempt not to submit to the nurses' definition of the situation.

> Well yes. I suppose that's part of illness, and he doesn't want to play chess with me anymore.

Such interactions were fairly common at ward rounds. The situation resembled a game where participants employed various strategies in order to gain dominance. Generally agreement was reached and all participants decided on a mode of action. In such a sitiation it was possible for the nurses to dominate the psychiatrists, by emphasising their therapeutic effectiveness and stressing the extent of their knowledge of the patients. As a result, the nurses could enchance their status both from their own perspectives and from those of the psychiatrists. Nevertheless these manipulations on the part of the nursing staff were not basically threatening to the psychiatrists, nor to the actual therapeutic situation. The nurses in this situation were attempting to enhance their status

and to relieve dissatisfactions relating to their role confusion, but did not intend to disrupt the entire ward authority structure. The central concern of providing treatment and care for the patients remained the priority and the basic goal for the therapists working on the wards. Conflict is not necessarily dysfunctional.

> Internal social conflicts which concern goals, values or interests that do not contradict the basic assumptions upon which the relationship is founded tend to be positively functional for the social structure. Such conflicts tend to make possible the readjustment of norms and power relations within groups in accordance with the felt needs of its individual members or subgroups. (Coser, 1956:151)

Several studies have discussed other methods commonly used by nurses attempting to enhance their status. For example Goodrick et al (1954) found that nurses frequently told jokes about the psychiatrists. This I found took the form of defining them as incompetent, or as rather similar to the patients. Charge Nurse Sangster described the new psychiatrist on West 4 in this way.

> We've had a new doctor come, he almost reminds you of the absent minded professor type, but likeable. But the kind of guy that you don't want to see him forget something and so you learn to lean over

> a little to help him and he feels very comfortable on this ward.

One day some nurses were commenting on the fact that while it was raining outside, two men in raincoats and hats were washing the hospital's windows. Nurse Henderson's comment was;

> You can see this is a psychiatric hospital! I once saw a psychiatrist standing holding an umbrella. He was washing his car in the rain.

Another tale was reported of a psychiatrist arriving on a ward in Crease for the first time. One nurse introduced him to a patient, but told him the patient was the charge nurse. The new psychiatrist then embarked on a long and technical monologue and read the ward files with the patient.

Other studies have reported different methods commonly adopted by the nurses. Scheff (1970:332) for example discovered that nurses could give or withold co-operation in an attempt to control the psychiatrists. This could involve witholding information, particuarly if the doctor was too demanding of the nurses. It also involved manipulating patients by encouraging them to accost the doctor with their requests. The most important sanction discussed was the nurses' non co-operation with the doctors' orders relating

to medication or seclusion. The nurses had control over these situations and could manipulate them if they so desired. While occurrences of this sort were not common, I occasionally observed the nursing staff employing such techniques in order to gain some temporary measure of control over the psychiatrists.

Only once did I hear of a nurse actually giving orders to a physician, and this was certainly not usual. Dr. Stone reported that he had once been walking down the hall in East 2 when Nurse Elliot had called to him; "Come here little boy I need you to do something".

Generally the nurses' attempts to enhance their status were quite subtle, even in those situations such as ward rounds where they were attempting to impose their ideas over those of the psychiatrists.

In conclusion, we see that nurses enjoyed some degree of success in channelling potential conflict in the wards and, in confrontations with psychiatrists, usually sought to enhance their status by redefining their roles as therapeutically effective and important.

Chapter VII

CONCLUSION

In this thesis I have attempted to depict, and examine the social implications of the therapeutic situation in a psychiatric hospital and the different psychiatric ideologies being practiced therein. I have taken data largely from interviews and conversations, compared the staff's observed life styles, drawn certain conlusions and considered previous research in similar fields. I was particularly concerned with the ways in which staff understood and defined their roles. In doing so, I have attempted to let the staff 'speak for themselves'.

I commenced this thesis by describing the ward organisation in Crease Clinic and the numbers and types of patients in these wards. A crucial factor which was considered throughout the thesis was that in the acute wards, that is East 4, West 4, West 3 and the Intensive Care Unit, the patients were officially considered as short term and therefore amenable to rehabilitation and

remotivation. In East 2, which contained organic brain syndrome patients, treatment centred around 'functional' nursing - the care for the physical needs of the patients. West 2 was designed simply to care for post-surgical patients. Details of the staff composition and their official duties were also given in this section.

In discussing the everyday activities, it was seen that these differed greatly depending on the wards. Occupational therapy and recreational therapy were avilable to all patients, but were primarily utilised by the patients from the 'acute' wards. West 3 was the only ward where official psychotherapy, that is, "Transactional Analysis", was carried on. This was largely due to the influence of the social worker on that ward. It was also seen that certain privileges were given to some patients once they were considered controllable by the ward staff. They were given 'grounds privileges', could attend activities such as dances, movies and bingo sessions, and were allowed to eat in the dining room. The official daily duties of the nurses were also discussed. These sections were essentially descriptive, but necessary as a background to the main body of the thesis

One of the main concerns of this study was the changing nature of Riverview's role. Alternative facilities for

the treatment and care of patients have resulted in a change in the type of patient being admitted to Riverview. A conference held at the hospital addressed this problem, and it was decided that Riverview should cease being a primary referral centre. Patients were only to be admitted there if they could not be taken care of in other psychiatric facilities, if they remained in those other facilities too long, or if they had become part of the 'revolving door' syndrome. The 'revolving door' phenomenon, as it was commonly termed, refers to these patients who entered an institution, were treated and discharged, and were then readmitted sometime later. This was a continuous process for a number of patients. As a result of this there had developed a recognition that Riverview's patients were becoming increasingly 'chronic' in nature. So it was also decided at this conference that a locked ward should be established in Crease Clinic to take care of 'emergency' - violent or suicidal patients. This ward was to replace the small Intensive Care Unit, and basically to take over its functions.

At that time these proposed changes gave rise to a certain degree of anxiety and cynicism on the part of some nurses. Some of the staff considered that the administration frequently proposed such changes, but that nothing

radical was ever implemented. This conference, however, did mark the commencement of a year during which considerable reorganisation took place, and within Crease Clinic, reorganisation became the basic preoccupation of, and source of anxiety among the nursing staff.

As a background to psychiatry as it was practiced in Crease Clinic, we analysed the theory of psychiatry and associated therapeutic techniques. The basic historical trends in psychiatry were seen to be the organic, the psychological and the magical. Psychiatry of course, claiming to be a scientific discipline, generally only admits to the existence of the first two at the present time.

The organic approach, which is likened to scientific medicine in general, searches for physical aetiologies, diagnoses and treatment methods. The major physical therapies are electronconvulsive treatment, psychosurgery- only occasionally used now - and chemotherapy. The efficacy of these treatment methods were considered although it was seen that there is considerable controversy over the matter within the discipline. Chemotherapy, most commonly used and most readily associable with medicine in general, is where most hope is placed for a final 'cure' for certain types of mental illness.

The psychological approach to mental illness was also considered, although psychoanalysis as such was not discussed in detail. Psychoanalysis is not a therapy frequently used in hospitals, particularly in large state institutions. Obviously there is simply not the time, nor the facilities to conduct classical analysis. The psychological approach, as it was discussed here, was considered in respect to various psychotherapies commonly employed in psychiatric hospitals. I emphasised those approaches on which Crease Clinic psychotherapy seemed to be based.

Frank's (1961b) theoretical framework was outlined, since it is perhaps the basic approach commonly adhered to by the nurses and psychiatrists. It concentrates on maladaptive responses which supposedly result from disturbances in the person's normal growth and maturation. These situations result in the person's growing up with conflicting feelings and urges. The therapy which follows from this theory involves supplying new interpersonal situations wherein the patient is supported in learning to deal with his maladaptive interpersonal and internal conflicts.

Carl Rogers's (1961) approach, which concentrates on personality change in the patient was also considered. Psychotherapy here involves the promotion of growth, improved maturity and the development of the functioning of the person as an individual.

Family therapy, as discussed by Ackerman (1961), was seen as another popular approach. This concentrates on the role of the family and evaluates emotional disturbances in family dynamics. Disturbances are made explicit and relearning is facilitated.

Transactional Analysis as developed by Berne (1966) was also outlined. The basic assumption here is that people have particular 'scripts' which they learnt in their childhood and on which they base their present actions. In the case of 'undesirable' scripts, therapy involves group settings where these scripts can be exposed in the hope that the individual will relearn his transactions.

In Crease Clinic I argued that specific psychotherapies were not generally adhered to, but an eclectic approach developed. It was also argued, following Frank's (1961) approach, that all psychotherapies are characterised by attempts to heal through persuasion and are based on hope. Hence the magical element emerges as playing a significant role in treatment.

The actual therapeutic situation was also examined. Both the therapist and the patient have certain expectations of each other's roles. The patient expects relief from the psychiatrist, follows his instructions and subjugates himself to the psychiatrist's authority. If the patient does not respond to treatment, it is frequently

rationalised by the psychiatrist that he did not follow the instructions or was non-compliant. Again it was emphasised that much of the efficacy of the psychiatrists' treatment procedure is dependent on faith on the part of both the interactants.

Psychiatrists it was argued, develop their confidence from the support of like minded individuals and from their experience and the knowledge received in their training. This is particularly crucial in a discipline such as psychiatry, where scientific knowledge is conflicting.

The role of the patient and the problem of mental illness were also discussed. It was seen that cross-cultural studies indicate that diagnoses are not standardised and that there is no one identifiable "thing" called mental illness. A related concern was the process by which a person comes to be defined as mentally ill, and comes to adopt that role. Various factors such as family, class, individual expectations, all played significant parts in this process. Involuntary hospitalisation was also recognised as an controversial topic.

The growth of psychiatry was seen as significant for society in general. More people are coming to be defined as 'sick' and in need of psychiatric treatment. The growth

of community facilities, it was speculated reflects this ever expanding field of psychiatry which increasingly pervades every aspect of a person's life.

In the analytic chapters, several questions were raised relating to the treatment and care of patients in Crease Clinic. I first considered the four psychiatrists interviewed, those who had worked in the Clinic during the entire time I did the field work. I was concerned first of all to examine the ways in which these four psychiatrists defined the wards on which they were employed and in the types of therapy which they considered dominant. It was seen that these four psychiatrists played an important role in redefining the ward orientations and the types of treatment administered there. This was largely based on the patient types which were being admitted.

All three British trained psychiatrists argued that the patients in the newly opened West 4 were acutely sick - psychotic. The patients were defined in terms of being dangerous, suicidal, and essentially threatening. The patients in West 3 were considered to be 'settled' or less 'disorganised', and therefore amenable to treatment. All the psychiatrists emphasised the importance of introducing chemotherapy, when a patient arrived on West 4, other therapies only being possible after medication had taken control. The Canadian trained psychiatrist on the other

hand considered that there was little difference between West 4 and West 3.

All four psychiatrists agreed on the nature of the patients being admitted to Riverview. They recognised that they were only receiving the patients that no other facility wanted. They did however perceive different problems relating to this. One of the major problems was in terms of manpower shortage and this was seen as a difficulty in the treatment and care of patients. Lack of continuity in treatment was the major problem.

Riverview's newly defined role was seen as advantageous by the three British trained psychiatrists. They considered that they could concert their efforts in dealing with a particular type of patient - the psychotic - and did not have to deal with neurotics or personality disorders. They also considered that psychiatry encompassed too many of society's problems and that they, as medically trained personnel, should basically deal in medical terms.

The Canadian trained psychiatrist held a different perspective. He considered that psychiatric practice should be expanded to cope with a number of social problems. His only complaint was that they did not have the power to enforce treatment on certain categories of people such as alcoholics or drug addicts.

As Crease became a secondary referral Unit, the 'revolving door' syndrome grew more apparent, but the psychiatrists did not admit that this was a problem for their everyday work, or for their role definitions. I suggested that the fact that these psychiatrists were taking part time jobs in the community facilities reflected some disillusionment on their part - and their desire to see effective treatment and discharge of acutely and not seriously ill patients.

In general these psychiatrists had rationalised the 'revolving door' phenomenon. It was emphasised by one of the psychiatrists that after all there was no guarantee of cure in medicine and far less in psychiatry. He considered that his job was adequately done if a patient stayed out of the hospital for three quarters of the year.

Generally patients stayed in Crease for six to eight weeks, but with the increasingly 'chronic' nature of the patients being admitted, another ward, West 2 was considered as necessary for extended care. Plans for this ward commenced when West 4 was redesigned, and it was eventually opened on the middle of 1977.

The knowledge that the patients they discharged would likely return in a few months did not appear to affect the capabilities of the psychiatrists.

This certainly did not result in any questioning of their efficacy as psychiatrists, or indeed of psychiatric theory and practice in general. We have shown on several occasions that psychiatrists readily adapt to the institutional possibilities and define and redefine their roles on this basis. In fact the psychiatrists occasionally saw the 'revolving door' phenomenon as helpful in that they already had knowledge of the patients diagnoses and past treatment histories.

The one Canadian trained psychiatrist placed the blame for the high return rate on ineffective follow up treatment programmes in the community. Of all the psychiatrists, he was probably most confident in his effectiveness as a therapist.

Generally the psychiatrists working in the acute wards defined those wards in similar terms. They had come to rationalise the problems in dealing with their 'revolving door' clients. Part of this ability to rationalise probably lay in the fact that they were mainly concerned with immediate treatment, in this situation and not with the causes of mental illness, or even the associated moral dilemmas. The psychiatrists frequently emphasised the fact that they just did not know enough about the aetiology of mental illness, so they did not talk in terms of prevention. The realisation that they had little time

in which to effect treatment, was another main preoccupation.

When it came to actual therapy, however, the psychiatrists differed in their perceptions. They each had specific ideas on how treatment should be conducted. In that sense, each subscribed to a particular psychiatric ideology. Nevertheless, they all made use of medication in the treatment of the patients. Chemotherapy, as one of the predominant modes of therapy in institutional psychiatry, was recognised by all of these psychiatrists. They saw it as necessary, at least in the initial treatment stages, in the patients' careers in Crease.

As far as individual therapeutic ideologies were concerned, one psychiatrist adhered only to the physical, and mainly utilised chemotherapy. He saw himself trained as a medical doctor, and considered that his knowledge ended at this point.

The training experiences of the four psychiatrists seemed to have some bearing on their therapeutic ideologies. British psychiatry is very much oriented to an organic approach to treatment, while Canadian psychiatry is much more eclectic, and involves an emphasis on chemotherapy, psychotherapy and family therapy. While it is difficult to generalise on the basis of this sample, the British trained psychiatrists seemed to reflect their original organic orientation, despite additional training in Canada

and despite their experience. The one Canadian trained psychiatrist emphasised a much more eclectic approach to treatment.

Despite this British 'organic' influence, all of the psychiatrists stressed that they utilised other therapeutic approaches and emphasised the need for personal contact with the patients. They all accepted that once a patient had gone through the initial 'settling in' period, psychotherapy could be useful. There was no consensus as to how long this period was, but three of the four considered that it should commence as soon as possible after the patient's arrival. The other psychiatrist, who was mainly oriented to the organic approach, thought that there should be some delay at least until the patient was in West 3. Even he emphasised the need to talk to the patients about their illnesses and their feeling associated with this. Only the Canadian trained psychiatrist considered that the family situation could be part of the therapeutic process and utilised this as much as he could in treatment and rehabilitation.

In general, none of the psychiatrists worked with specific psychotherapeutic models as they were described in the textbooks. In depth psychotherapy was seen as impossible, given the patient types and given the lack of time.

All four psychiatrists had developed eclectic approaches to therapy and had been influenced by their training, through personal experience and by adaptation to particular ward situations.

All the psychiatrists in Crease displayed professional detachment in interacting with patients. An important element in their therapeutic efficacy was their confidence that they had gained through training and experience, that they have the ability to make judgements and prescribe what is best for the patients. This detachment and confidence on the part of the psychiatrists was frequently observed in Crease Clinic. These situations conformed to those described by Frank (1967) and Freidson (1970).

It can of course be argued that because of their professional detachment, psychotherapy may not have always been effective. Some type of empathy is generally required. It can also be argued that effectiveness was lessened because of the discrepancies of social class and ethnic origin between the psychiatrists and the patients.

The nurses were employed on the wards for most of their working day and therefore were familiar with the patients their changing behaviour patterns and their attitudes. The nursing staff attitudes were of major importance to this study. Like the psychiatrists the nurses defined the wards

in terms of the types of patients housed therein. They were, however, more preoccupied with the fact that they were dealing with 'chronic' patients and therefore opposed the official definition of the acute wards as 'acute.'

The realisation on the part of the nursing staff that they were no longer receiving acutely ill or short term patients was a considerable problem for them. They had been trained to deal with neurotic patients and, even in Crease, had had years of experience, in dealing with that type of patient. This presented problems for most of the nurses in defining the ward situation, its purpose, and in defining their own specific roles. Like the psychiatrists however, they did agree that there were certain benefits to the 'revolving door', in that they knew who they were dealing with.

As the Clinic was undergoing change, problems were presented to the nursing staff, mainly in terms of patient type, staff shortage and anxiety about the reorganisation. West 4 and East 4 in particular were faced with these problems, and within these wards there was confusion over the definitions of the therapeutic situation. Once West 4 was established as a locked admitting ward, however, these definitions were quite explicitly stated and its purpose

was recognised by all the staff members. The Intensive Care Unit had had almost the same function, and the staff there were quite clear as to its goals.

West 3 was probably the least organised ward in terms of having the loosest definition of the therapeutic situation. Even the charge nurse did not admit to subscribing to any particular approach. The nurses in West 3 then had a wide range of definitions concerning the patient types and the treatment administered on the ward. Even within the wide variety in perception of the therapeutic situation on West 3, it seemed to function quite adequately, with less confusion than the other wards. West 3 however, was not directly involved in the changes, so there were not the same anxieties. The nurses then probably carried out their work with little interference from the other nurses and psychiatrists. East 2 had a simple and clear definition of the ward situation, based on the patient types and the ideas of the head nurse, who had worked in such wards for nineteen years. Most of the nurses there agreed with this definition, although there was opposition from one staff member. While West 2 was simply designed to care for post-surgical patients, the nurses there all agreed that part of the ward's function was to care for the psychological aspects of the patients. On each ward, most

nurses agreed with the official definition of the ward therapeutic situation, although a few perceived them in different ways than the majority.

Apart from their perceptions of the ward situation the nurses had specific ideas on their own role definitions. The majority of the nurses defined their roles in detached-professional terms. We speculated that disillusionment frequently sets in and in some cases idealistic conceptions of curing the patients die away.

There seemed to be some broad difference between male and female nursing roles as they were perceived by individual nurses. The male nurses, in what ever ward, defined their roles as similar to those of the psychiatrists - as detached advisors and counsellors. The female nurses were more concerned with rehabilitation in terms of making the patients aware of the problems they were to face in the outside community. So, in a sense, the male nurses were concerned with psychological aspects, while the female nurses concentrated on 'reality', on everyday problematic situations. A few of the nurses held different conceptions of their roles - emphasising in-depth psychotherapy, or at the other extreme - pure custodial or physical care. On East 2 and West 2, where nursing was predominantly physical, the female nurses generally defined

their roles in these terms, although not all of the males held similar conceptions.

Training did not seem to have any bearing on role perception, in that there seemed to be no difference between British and North American trained nurses. Position in the ward hierarchy seemed to have no bearing on role definition either, nor did length of experience in nursing. I suggested that the ward ideology as it was defined by the charge nurses, and the ideas of the other nurses, influenced nursing staff into defining or redefining their roles to suit particular situations. Moreover, the aides, those nurses with no training, held conceptions of their roles which were similar to those of the majority of the nurses.

Satisfaction with work was seen as part of the problem which related to role definition. On West 2 and East 2, the male nurses expressed dissatisfaction with the predominantly physical therapy on the wards, they were concerned to emphasise psychological aspects as they could implement them. A number of nurses also expressed dissatisfaction with the patient types being admitted to the acute wards, and the problems of dealing with them in therapeutic terms. Disillusionment relating to the 'revolving door' syndrome was common. Given the difficulties of being 'therapeutic' in this situation, the major response on the part of the nurse, was to detach. They also expressed dissatisfaction

over the problems involved in isolating their roles, or rather their function on the wards. Much of the therapeutic responsibilities lay in the domain of the other therapists - psychiatrists, occupational and recreational therapists and social workers. There was also controversy over British versus Canadian training, although the basis for this did not seem to lie in different role conceptions. I speculated that this was a result of complaints on the part of the British trained nurses and how they perceived Riverview Hospital.

In general most of the nurses acted in accordance with their stated role definitions in the performance of their everyday duties. It seemed that they were more influenced by the ward situation than any other factor. A few nurses who ideologically opposed the prevailing ideas on the wards, acted in a manner which departed significantly from their role definitions. This seemed a result of the restrictions imposed upon them by the other staff members. There was a certain degree of ambivalence over both role definitions and work styles anyway, from most of the nurses.

All of the nurses, no matter how they defined their roles, demonstrated certain common patterns in interacting with the patients. Probably because of the strains inherent in the ward situations, they almost all withdrew from the patients from time to time, both physically and psychologically.

They also all demonstrated their superior status relative to the patients by various methods.

Anxiety regarding change was always a part of the pre-occupations of the nursing staff. Throughout the year, all the nurses expressed anxiety and concern over the impending changes. These perceptions were magnified as each ward was threatened with reorganisation. It was not so much that they opposed the changes, as that they had no knowledge of how and when these changes were to occur, or how they were to affect their jobs. The uncertainty inherent in the situation gave rise to a great deal of anxiety and tension.

The nurses placed most of the blame for their anxiety on the lack of communication within the hospital and the seemingly arbitrary decisions made by the administration. This was one of the pervasive aspects of life in Crease Clinic. While such situations are likely to be found in any occupation, as common complaints by staff anywhere, they seemed to be intensified in that year of change in Crease.

The nursing staff were also in a dilemma which arose from their role definitions. Some were constantly competing with the psychiatrists for control over the patients' psycho-therapy, and for other responsibilities. They generally claimed that they had more knowledge of the patients than did the psychiatrists and therefore were important in the therapeutic process. Other nurses who emphasised a 'team'

approach were usually willing to act as co-workers, so this did not present such a problem to them.

The nurses who did consider their roles as psychotherapeutic frequently utilised several methods to impose their ideas on the psychiatrists. This usually took place at ward rounds. Even those nurses who did not define their roles as psychotherapeutic used techniques to enhance their status as nurses. In general actual conflict rarely arose. The nurses channelled potential conflict, by redefining their roles as therapeutically important, by demonstrating their knowledge of the patients.

In studying Crease Clinic and the ongoing activities on the parts of the therapeutic staff we have considered several problems. The most important was the analysis of various psychiatric ideologies, perceptions of the patients and the wards, role definitions and attitudes to treatment. As we have seen each ward in Crease Clinic was characterised by a multitude of various perceptions regarding those matters on the parts of both the nurses and the psychiatrists. Despite the variety of opinions and the diversity of statements by the staff on each ward, there was adequate agreement over various matters to ensure that some type of treatment, however eclectic, could be practiced.

The main problem lay in the division of labour on the

wards. We saw that there was considerable overlapping of responsibilities and much uncertainty over the issue of "who should do what to whom?" Nurses in particular were expected to act in accordance with the orders of several of their superiors. This problem appeared to be solved by a process of negotiation. It was the negotiation which prevented disorganisation from erupting in the situation where the various therapists carried out their everyday work. This negotiation however was not a matter which was generally discussed, particularly in regard to varying ideological perspectives. When it was discussed, it was on the level of particular and immediate tasks which had to be done. As such this observation may contribute to an understanding of how people function on a day-to-day basis in organisations generally.

Another problem concerned job satisfaction. The problems faced by the nurses and psychiatrists can be assumed to be similar to those faced by personnel in any occupation, although the subject of pay was not a major preoccupation in this situation. One aspect of nurses' and psychiatrists' job satisfaction, related to the retaining of optimism in the treatment and care of patients in a situation where optimism seemed unlikely. Indeed optimism was rare. Most staff had rationalised the problems involved in their work over a period of time.

Finally the ways in which the staff managed to cope with what many of them perceived to be "regressive" institutional change has some relevance to the study of the sociology of psychiatric institutions. The examination of these processes will probably have some direct bearing on future studies of state mental hospitals undergoing similar change.

APPENDIX A

NURSING STAFF INTERVIEWED

Name*	Ward	Sex	Status on Ward	Place[1] of Training	Qualifications[2]	Experience in Psychiatry (in years)
Sangster	E-4/ W-4	F	C.N.	N.A.	Psych.	8
Callaghan	E-4	M	N.1	N.A.	Psych.	15
Read	E-4	M	N.1	N.A.	Psych.	7
Collins	E-4	F	N.1	B.	Psych.	6
Walsh	W-4	M	C.N.	N.A.	Psych.	8
Phillips	W-4	M	N.1	B.	Psych.	5
Lang	W-4	F	N.1	N.A.	Psych. & R.N.	5
Lawless	W-4/ ICU	F	N.1	N.A.	Psych. & R.N.	25
Selvin	W-4	M	N.1	B.	Psych.	20
Mercer	W-4	M	N.1	B.	Psych. & R.N.	9
Gladwin	W-4	M	N.1	N.A.	Psych.	13
Hansen	W-4	F	N.1	N.A.	Psych. & R.N.	11
Morgan	W-4	F	N.1	N.A.	Psych.	14
Helm	W-4	M	N.1	N.A.	Psych.	12
Todd	ICU	M	N.1	N.A.	Psych.	11
Bean	W-4 ICU	M	Aide			25
Cartwright	W-4	F	Aide			12

1. Nurses trained in Britain are denoted by "B"; those trained in North America, by "N.A.".
2. Those qualified as Psychiatric Nurses are denoted by "Psych" and/or those qualified as Registered Nurses, by "R.N.".
* As was noted earlier, all names of staff have been changed.

Name*	Ward	Sex	Status on Ward	Place of Training	Qualifications	Experience in Psychiatry (in years)
Russell	W-3	M	C.N.	N.A.	Psych.	5
Henderson	W-3	F	N.2	N.A.	Psych.	20
Robinson	W-3	F	N.2	N.A.	Psych.	14
Bacon	W-3	F	N.1	B.	Psych. & R.N.	10
Paterson	W-3	M	N.1	B	Psych.	14
Cramer	W-3	M	N.1	B.	Psych. & R.N.	11
Nelson	W-3	F	N.1	N.A.	Psych.	3
Green	W-3	F	N.1	N.A.	Psych.	5
Benish	W-3	F	N.1	N.A.	Psych.	8
Moss	W-3	M	Aide			5
Cameron	W-3	F	Aide			20
Hemmings	W-3	M	Aide			8 mos.
Simmonds	W-2	M	C.N.	B.	Psych. & R.N.	11
Frieson	W-2	F	N.2	N.A.	Psych. & R.N.	10
Lambert	W-2	F	N.1	N.A.	Psych. & R.N.	5
Scanlon	W-2	M	N.1	N.A.	Psych.	14
Enders	W-2	F	N.1	N.A.	Psych. & R.N.	6 mos.
Hadden	W-2	F	N.1	N.A.	Psych. & R.N.	1
Conway	W-2	M	N.1	B.	R.N.	2
Trotter	E-2	F	H.N.	N.A.	R.N.	19
McDonald	E-2	M	N.2	N.A.	Psych. & R.N.	8
Meredith	E-2	M	N.2	B.	Psych. & R.N.	22
Robb	E-2	M	N.1	N.A.	Psych.	6
Matthews	E-2	F	N.1	B.	Psych.	7
Guthrie	E-2	F	N.1	N.A.	R.N.	1
Dennis	E-2	M	N.1	B.	Psych. & R.N.	14
Elliott	E-2	M	N.1	N.A.	Psych. & R.N.	21

Name*	Ward	Sex	Status on Ward	Place of Training[1]	Qualifications	Experience in Operating Room (in years)
Purves	O.R.	F	N.2	N.A.	R.N.	12
Pilling	O.R.	M	N.1	N.A.	Psych.	10
Walker	O.R.	M	N.1	N.A.	Psych.	9 mos.
Kaiser	O.R.	F	N.1	N.A.	R.N.	2
Pringle	O.R.	F	Aide			4
Frank	O.R.	F	Aide			2

APPENDIX B

RIVERVIEW PATIENT DIAGNOSIS BY TYPE OF ADMISSION: 1976

	Psychosis	Psycho-Neurotic	Brain Syndrome
First Admission	269	52	67
Readmission - same facility	731	53	61
Readmission - other mental health facility	10	-	7

	Personality Disorder	Mental Retardation	Other and Undiagnosed
First Admission	91	5	34
Readmission - same facility	108	3	32
Readmission - other mental health facility	5	1	113

APPENDIX C

WEST 3'S THERAPEUTIC COMMUNITY

When you become a patient on this ward you enter a Therapeutic Community.

This is a group comprised of all the patients and staff on the ward a sort of miniature society.

Its purpose is to help you and all the other patients get well.

THIS IS HOW IT WORKS . . .

We feel and behave in the hospital community much as we do in the world outside with our families, friends, and associates.

SO . .

We get to know each other, as best we can, so that we can share with one another our thoughts and feelings and our impressions of each other.

THIS WAY . . .

We can learn more about ourselves and help others see themselves as we see them, so that we can all make constructive changes in our lives.

WE EXPECT THEN . . .

That as patients beging to know each other better, they will be able to make specific comments and recommendations for other patients and the ward in general.

FOR EXAMPLE . . .

To decide on levels of responsibility for our fellow patients; that is, when are they ready to have their clothes, to be out on grounds, to go hom on weekends.

RESPONSIBILITIES

Members at every level are expected to attend all ward activities. Before a member requests an increase in level he must show the community that he is capable of handling the responsibilities of his present level.

LEVEL 1 Extends for a minimum of 48 hours after admission for all new members. The member is confined to the ward, wears pyjamas and dressing gown and takes meals on the ward.

LEVEL 2 Attending the meetings regularly; discussing reason for coming to hospital; co-operating with O.T. & R.T.; maintaining bed area and personal appearance. Level 2 members will wear an identification badge.

LEVEL 3 Same as Level 2 plus taking initiative in socialising with others.

LEVEL 4 Same as Level 3 plus being a "buddy" as requested by secretary.

LEVEL 5 Same as Level 4 plus helping other members with difficulties.

LEVEL 6 Same as Level 5 plus making realistic plans for his/her future discharge.

PRIVILEGES

The member may only be off the ward if accompanied by staff. The member attends Occupational Therapy accompanied by staff.

The member may only be off the ward if accompanied by staff, the member wears street clothes and goes to the dining room in company with staff.

May use hospital grounds in company with Levels 4, 5, or 6 and may vote at community meetings.

May use hospital grounds unaccompanied. Weekend passes at doctor's discretion.

Level 4 plus outings with responsible relatives or friends.

Level 5 plus day passes while searching for employment. (Member must inform staff of when and where he will be going.)

APPENDIX D

RIVERVIEW HOSPITAL: DEPARTMENT OF NURSING

ROLE OF THE NURSE

The role of the nurse centres around his/her relationship with patients and the assistance he/she provides patients in meeting their basic health needs. The nurse has a unique opportunity to make a distinct therapeutic contribution while providing intimate care to the patient during the twenty-four hour period. The nurse utilises every nurse-patient contact to observe the patient's appearance, behaviour and interaction, to obtain required data for assessment of the patient's needs. He/she helps the patient; to interact with others; to assume responsibility in caring for physical needs in a socially acceptable manner; to make decisions; to dress to acceptable standards; and to use leisure time effectively.

The nurse collaborates with other members of the treatment team in determining the patient's health needs and therapeutic programme then administers and/or co-ordinates the prescribed treatment. The nurse, in relating to the patient and treatment team, is aided by his/her knowledge of behavioural science and an awareness of his/her own attitudes and responses.

The nurse's acceptance of the patient is an active process designed to convey a respect for him as an individual human being.

APPENDIX E

CREASE UNIT NURSING STAFF: APRIL - MAY 1976

	East 2	East 4	West 2	West 3	West 4/ I.C.U.	O.R.
Nurse 3	1	1	1	1	1	-
Nurse 2 Administrative	2	2	1	2	2	-
Nurse 2 Clinical	1	1	1	2	1	1
Nurse 1	13	11	19	12	19	3
Psychiatric Aid	8	7	8	7	9	-
Nurses Aide	-	-	-	-	-	2
Summer Relief Aide	3	3	-	1	2	-

APPENDIX F

CREASE UNIT NURSING STAFF: MARCH 1977

	East 2	West 3	West 4	O.R.
Nurse 3	1	1	1	-
Nurse 2 Administrative	2	1	2	-
Nurse Clinical	-	1	2	1
Nurse 1	11	15	21	1
Psychiatric Aide	10	5	5	-

APPENDIX G

RULES FOR PATIENTS ON GROUNDS PRIVILEGES

RECREATIONAL ACTIVITIES

Bowling, Checkers, Billiards, Softball, Golf, Tennis, Library, Swimming, and many other activities are available. Check the "Leader" for time - days.

COFFEE SHOP

There are two coffee shops: one at the main bus stop near the post office, the tuck Shop run by the Institute for the Blind and the other in Pennington Hall, operated by the Mental Health Association.

GROUNDS SUPERVISOR

You will become acquainted with him when he interviews you for ground privileges. Do not hesitate to contact him at any time for further information. He is there to help you in any way possible, and brief you on hospital regulations.

POINTS FOR QUICK REFERENCE

1. Sign register on ward as to where you are going and upon returning.

2. Report back to your ward promptly as per schedule and before meals.

3. Be friendly, tolerant and courteous toward your fellow patient but curb your tendency to over familiarity.

4. You will be expected to conduct yourself in a responsible manner and be discreet in your associations with others.

TIME SCHEDULES

Patients entitled grounds privileges must return to their wards by dusk. After dusk they may be off the ward only to attend approved activities. Dusk will occur at the following hours throughout the year.

January	4 PM	July	9 PM
February	5 PM	August	8 PM
March	6 PM	September	7 PM
April	6 PM	October	5 PM
May	8 PM	November	4 PM
June	9 PM	December	4 PM

Patients should familiarise themselves with grounds privilege policies from the charge nurse of their ward.

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