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References are available on request to Dr Rutherford.

Working in a child guidance clinic

DEAR SIRS

In my previous job I worked as a registrar in a child guidance clinic; before that I had always worked in acute adult psychiatry. This clinic and its practice was new in many ways: it was outside a hospital, there was less emphasis on the medical model and pharmacological treatment, less use of a classification system and less clear sense of hierarchy and boundaries between the disciplines. This apparent lack of structure was not reflected in a typical day: all contact with patients was arranged by appointments; the diary was fully booked hour after hour, weeks in advance; and there was no pager to interfere with sessions (what a delight).

As a newcomer it was hard to define one's own (and others') identity in, and particular contribution to, the service. Treating patients within their social and emotional environment (the family) was difficult and challenging. As the biological model of mental illness did not predominate, problems were understood and treated in psychological terms. These views were very much fostered by the non-medical colleagues and the particular interests of the psychiatrist.

Working in a multidisciplinary system where there is less emphasis on the medical model and hierarchy broadened my perspective. A constant appeal to defining and identifying the special abilities of myself and my colleagues made me aware of the available resources and their contributions to the management of a case.

I believe that every trainee should be strongly encouraged to gain experience in child and family psychiatry in order to enhance self understanding. This will then be reflected in treatment. I also propose that every junior doctor should at least have one supervised psycho-analytic experience. I would recommend an early introduction into such a job provided there is adequate supervision.

I wonder if there are trainees and consultants who share my views?

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Crisis team in South Lewisham

DEAR SIRS

The Crisis Team in South Lewisham has been in operation since January 1992 and consists of an approved social worker and community psychiatric nurse, with input from a consultant psychiatrist.

The possibility of the CPN being able to prescribe medication from an agreed list of drugs to a client in crisis, to alleviate acute distress and possibly prevent hospital admission, was examined. To obtain their views on this proposal a questionnaire was sent to GPs, consultant psychiatrists and CPNs; 17 out of 30 GPs, 12 out of 16 psychiatrists and 13 out of 20 CPNs replied.

Fifteen GPs agreed that CPNs should prescribe in crisis situations from a negotiated list but suggested that GPs be made aware if a CPN prescribes. Nine psychiatrists felt that it was a 'positive' step but some felt it may not be useful; 11 CPNs agreed with the principle.

As to whether CPNs should also prescribe as part of on-going care, ten GPs, seven psychiatrists, and nine CPNs said yes and two GPs, five psychiatrists, and three CPNs, no.

Thirteen GPs, seven psychiatrists and 11 CPNs had confidence in nurses prescribing in crises but with such comments as "with adequate training and supervision" and with the suggestion that crises are the worst time for the nurse prescribing. Also, concerns about possible drug interactions, poor communication and the blurring of roles were raised. However, positive factors could be saving of time in crises thus relieving acute distress, increasing the effectiveness of community nurses, and greater flexibility. When asked who should take responsibility for nurse prescribing, 14 GPs and six psychiatrists felt that the psychiatrist should while eight CPNs felt that nurses should take their own responsibility.

The range of medication that CPNs could prescribe was considerable. GPs felt that tranquillisers, antidepressants and hypnotics should be included but the psychiatrists and CPNs did not include antidepressants. The time limit placed on prescriptions ranged from one dose to several days, i.e. to cover a weekend. On what precautions were needed for such a policy to work, suggestions included adequate training, support and regular updating. As to whether a CPN who had known clients for years should be able to alter times and dosages of medication, most GPs (12) said yes, as did seven psychiatrists and 13 CPNs.

Psychiatrists and CPNs on the whole are therefore in favour of a CPN being able to "prescribe" from a small negotiated list of drugs in crisis situations. As long as the psychiatrist took responsibility for the nurse prescribing they would have confidence in the CPN to carry out such a function.

Communication between CPN, psychiatrist and GP was felt to be the most vulnerable point. So, for

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such a policy to work a clear "fail safe" method of preventing communication breakdown between the three parties must be developed, especially if medication were to be prescribed over a Bank Holiday weekend for example.

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A disturbed unit

DEAR SIRS

The management of aggressive, violent psychiatric patients is a current phenomenon evoking considerable interest. My views on this issue derive from my recent role as the responsible clinical psychologist in such a unit for mentally handicapped patients at Aycliffe Hospital, County Durham.

Over a one-year period there were 27 new admissions, one third from the community (16 female and 11 male patients), with presenting violent behaviour. There was no dichotomy with regard to age (mean 34 years), but the men were more intelligent (upper-mildly-retarded) than the women of moderate retardation. Diagnostically, they included schizophrenia, organic involvement, behaviour disorders and psychopathy. The women have tended to be more psychotic (3:1), and there were 4:1 male: female psychopaths. The population then was comparable to that referred nationally to such units (HMSO paper, 1990).

The discharge rate, back to the hospital or to the community, was 47% during this year. Diagnosis was irrelevant to this. Of the 12 violent incidents during the year committed by seven patients, IQ, age or diagnosis was not related, nor was medication. The male patients spent twice as long in the unit following their violent outburst as the females.

The impression gained from these observations is that, in such a disturbed unit, violence in the mentally handicapped reflects social factors rather than a mental illness.

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Poles – unsuitable for psychotherapy?

DEAR SIRS

For nine years I have provided psychiatric consultations to Polish-speaking patients at "The Polish Clinic" in Harley Street. Being predominantly a psychogeriatrician, I appreciated the opportunity to use other skills such as psychotherapy. However, my enthusiasm has been clouded by my total failure to prevent drop-outs. Polish patients to whom I have offered psychotherapy (brief analytical, behavioural, cognitive) have rarely completed more than three to four sessions before they disappear without saying whether they felt better or worse. The total number was approximately 30, aged between 16–65, articulate, often living in this country for several years, with reasonably well-defined problems and not suffering from mental illness. For comparison I recall a group of similar patients whom I treated as a senior registrar at Guy's Hospital with psychotherapy and when there were few drop-outs. Why?

Polish history abounds in tragic and unexpected events beyond the nation's anticipation or control. Friends and relations (good objects) often disappeared without warning or farewell (wars and foreign occupations often responsible). They vanished irretrievably or, if they came back, were changed or perceived as changed. For many Poles the Piagetian concept of "object permanence" has been repeatedly subject to assault. Z. Mrozek, a contemporary Polish playwright, put forward in his play *On Foot* that only loose and illogical, emotional/cognitive systems can withstand repeated assaults. By their initial enthusiasm for psychotherapy Polish patients may have hoped to receive much needed care but, when the relationship required real commitment, the fear of being exposed as vulnerable and then abandoned pushed them into flight. Some have been emotionally frozen due to failure to mourn as in *The Iceman Cometh* by Eugene O'Neill. "Unfreezing", a necessary and unavoidable state in psychotherapy, could evoke a fear of total "melting". A desire to be close may become coupled with a defensive wish to remain unreachable. Only a solid inner core impregnated with good and reliable internalised objects can defy archetypal fear of annihilation in intimate relationships (Jung, 1939).

I am sure this difficulty in developing and maintaining intimate relationships in psychotherapy affects not only Poles, but other nationalities, for whom fight for survival overrides the capacity for care and commitment, a final acknowledgement of separateness and individuation in relationships.

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