ON OPENING AN ADOLESCENT UNIT*

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THE main purpose of this paper is to report our experience in developing a psychiatric in-patient unit for adolescent boys. The Unit is known as Beech House and contains 16 beds and has been operating since January, 1959. It is a non-statutory ward and is the first treatment unit of this kind attached to a large provincial mental hospital such as St. Augustine's. Its catchment area is limited to the South-East Metropolitan region which comprises Kent and part of East Sussex. Only exceptionally are cases from outside these two counties accepted into the unit.

The present trend in this country is to open more of such units for the residential treatment of adolescents and the observations that we have made in the first nine months of the Unit's existence may be of interest to those who will be engaged in similar work in future. I shall describe the original blue-print and then point out the various modifications that had to be made. I shall deal essentially with changes of policy as they affected the administrative and therapeutic structure of the Unit.

DESCRIPTION OF WARD

The first main problem that we had to solve was one of planning. The Unit is housed in two villas situated at the periphery of the hospital estate in nearly open country with a few adjoining woods. These twin buildings, two storeys high, were originally designed to be self-contained wards. They were not altogether suitable for our purpose and had to be structurally altered to suit our needs. The Hospital Nurses' Training School is housed on the ground floor of one of these villas, and only the first floor is available to us. Ideally we should have preferred one large self-contained ward equipped to serve the needs of 16 in-patients rather than two separate buildings. The school, considered very much as a link with the outside world, would have been better placed in a building set apart on its own. "Going to school" would then have approximated more closely to the routine experience of ordinary schoolboys. We had to make the best of the available accommodation and eventually we decided to use the one whole villa allocated to us as the main living centre during the day. The school became included in it.

The ground floor comprises a large dining room and a common room equipped with table tennis, billiards and television set. The doctor's clinic, charge nurse's office and kitchen are also situated on this floor. The first floor, formerly a large dormitory, has been altered to include the school as well as separate rooms for the therapist, the P.S.W. and the teacher. Rooms have been

* This talk was given at the South-Eastern Divisional meeting of the R.M.P.A. at St. Augustine's Hospital, on 7 October, 1959.

https://doi.org/10.1192/bjp.106.445.1320 Published online by Cambridge University Press

set aside for various activities such as carpentry and clay-modelling. One room is also available on this floor for the temporary seclusion of very disturbed patients.

One disadvantage resulting from the close proximity of the school to the ward is that no safe curtain exists to prevent the spill-over of negative reactions from one quarter to another. It is more difficult, for instance, for the anxious child who acts out aggressively in the school to feel safer in the ward when one is a mere extension of the other. In this way, aggressive reactions in too confined premises tend to diffuse very widely because adults become closely identified with one another.

The sleeping quarters are situated on the first floor of the other villa, known as "Redwood". There are 10 individual bedrooms and a 6-bedded dormitory reserved for newly admitted boys. Individual rooms are allocated by order of seniority or merit. A fairly large assembly room is used in the evening by boys who wish to watch television programmes. I must confess that this television set was originally placed there to induce our patients to move over to their sleeping quarters without murmur. The idea has worked out fairly well. Only the more senior boys are allowed to sit up late to watch T.V. programmes of special interest. Normal lights out is at 10 p.m. The remoteness of the sleeping quarters from the ward has had many disadvantages. There is no supervision there during the day and for this reason the boys are not allowed to go to their room. Some have undoubtedly resented this lack of privacy, particularly when they wanted to isolate themselves from the group.

Staff Organization and Aims

The organization of such a unit must be flexible enough to meet quite widely divergent needs; it must accommodate the youngster who has made a psychotic type of withdrawal as well as the child who is passing through a phase of acute acting-out and presents severe behaviour problems. This necessitates the combination of the special educational techniques of the schools for maladjusted children with the psychiatric and nursing techniques developed from experience in mental hospital care.

Our primary aim in such a unit is to modify the more grossly pathological defences. The child who, through his own insecurity and inadequacy, has drifted too far into a world of fantasy and fears reality, needs a community in which he can gradually learn to act out and find satisfaction in day to day living.

The staff comprises the physician in charge, who supervises the administration and clinical aspects of the Unit. He has under his direction a full-time male therapist who co-ordinates individual and group therapy programmes. Stress is laid on environmental therapy which is based upon the therapist, teachers and nursing staff working as a team. Regular meetings are held in which observations are shared and attitudes to the patients discussed. A diagnostic conference is held on every new case one month after admission. Observations and opinions from all the members of the Unit, are pooled and a collective decision made regarding future therapeutic procedure.

The nursing staff consists of two charge-nurses, two male staff-nurses, two female assistant-nurses and two student nurses. They rotate every eight hours in shifts. Two nurses are on duty at night between 8.30 p.m. till 7 a.m.

The nurses' duties most nearly correspond to those of parents. They attend to the patients' material needs, but are also closely involved with them in the day to day living situation. They participate actively in recreational activities

https://doi.org/10.1192/bjp.106.445.1320 Published online by Cambridge University Press

with them and try to provide the authority and affection of parental figures. Female nurses have been accepted as mother figures and one middle-aged nurse has succeeded particularly well in this task.

It was soon noticed that the greatest call on the resources of the nurses came in the evening period after 6 p.m. when organized activities and psychotherapy have ceased. This is the time when normally at home, family life comes into its own. It is perhaps ironical to say that at the Unit it is often a time of strife! This period brings with it what is probably the nearest approximation to the home situation. Old anxieties and aggressive responses are reactivated and readily give rise to rebellious behaviour patterns in some boys, whilst others manifest their dependency needs by their increased attention-getting behaviour with adults. To alleviate the nurses' task we have organized recreational and social activities on several evenings during the week.

The Unit cannot be run in isolation from the outside social environment as in the most conventional type of adult psychiatric ward. The Psychiatric Social Worker is therefore primarily employed in maintaining close links between the patient and his family. By regular home visits, as well as interviews at Beech House, the parents are brought into the therapeutic situation as much as possible. We also aim to maintain contact with the referring clinic and get their co-operation over family case work.

The school is under the control of the Kent Education Committee which supplies the two teachers attached to the Unit. The boys spend four hours in the school each day from Monday to Friday. They are divided into groups and receive individual attention. The school programme is extremely flexible and varied and aims to be therapeutic as well as educative. The teacher's approach is guided by the level of emotional disturbance in each boy rather than by the level of scholastic attainment.

Change in Concepts

Since the unit opened some of our original concepts have had to be significantly modified. We started with the premise that permissiveness should be the governing principle underlying our attitude to the patients. We inferred that controls should be reduced to a minimum and instituted the open door policy as it is applied to most of the wards in the hospital. We soon found that we were left by ourselves in the ward whilst our patients roamed freely about and committed an increasing number of destructive acts in the vicinity. The Unit seemed to have no other function to them but to provide food and shelter. The greater freedom they enjoyed the less inclined they were to become involved with us.

A crisis was soon upon us when a small rebellion suddenly broke out. The leader was an aggressive psychopathic boy who persuaded a group of patients to accompany him to a near-by wood. He and his retinue refused to return to the ward and slung abuse at the nurses. All seemed greatly encouraged by their leader who brandished a 6-inch self-made dagger and blustered threats. With approaching darkness the situation grew more enervating for the staff, who felt powerless. However, with skilful manoeuvring the group was split, its leader isolated and the rebellion brought under control. Needless to say we had to take notice of this rather ugly reality situation and limit our patients' freedom. It almost seemed as if the Unit's survival was at stake. The open door became the half closed door, no boy was allowed out without escort unless he could be trusted and indicated beforehand where he wanted to go. Anyone guilty of an

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offence outside the Unit automatically became gated. This form of sanction re-established confidence and security in the staff and patients.

Analysis of the situation suggests that the crisis could be attributed to three sets of factors. In the first instance the group contained too high a proportion of aggressive boys with delinquent tendencies. In future a more discriminate selection would be required and no more than two or three dissocial boys admitted at any one time. Secondly, it must be remembered that the staff had only just come together to form a new team. Some had only just met and were therefore untried and unaccustomed to one another, the majority were inexperienced with the residential treatment of adolescents, all were anxious and relatively untrained in their new position. In the case of the nurses few were able to act spontaneously in situations demanding immediate intervention. It is no use waiting for doctor's orders when a boy breaks a window. The very word permissiveness in many instances seemed to inhibit the nurses and one could undoubtedly speculate with interest on its various interpretations. It is a fact that in the early days of the Unit permissiveness was understood to mean an attitude of benevolent neutrality, its application sometimes demanding an almost masochistic sense of leniency. This fits in with the traditional role of the mental hospital nurse who is trained to be a passive observer with custodial duties in adult psychotic wards. Nothing could be more phoney to adolescents, who need to feel that adults in charge of them can experience appropriate emotional responses and are not afraid to show disapproval if necessary when wilfully defied. This is what a normal child expects from his parents and indeed the basis of any identification with the parents must be the truthfulness and predictability of parental responses. For it is only then that a child will begin to accept and respect their authority. Perhaps our greatest mistake when we started was to ignore our patients' profound need for parental attitudes from us and their relative indifference to our good sibling-like comradeship. They need to be guided as well as sympathetically treated.

Our good intentioned attempt to institute a profoundly liberal regime had the effect of plunging a group of disturbed adolescents into a structureless society in which there was no effective authority and therefore no adequate safeguards against their own destructive impulses. The rebellion certainly provoked adults in charge into showing their authority by re-establishing some controls without which our patients did not feel secure.

Sensing our passivity as an anachronism our rebels quickly forced us back into realistic parental roles. It is perhaps characteristic that all the time the Unit was wide open the usual reaction of the boys to our approach was one of flight. "Running out to the wood" became a familiar pattern and our contact with our patients deteriorated into a vast game of hide and seek. Our patients refused to get involved personally with us unless we could show them we were masters in our own house.

Discussion

Adolescence, the so-called "awkward age", is often regarded as an abnormal phase of normal development. The rising generation causes resentment, conscious or otherwise, in adults who know they will eventually be displaced. As a result the balance between parental authority and the adolescent's longing for independence is a very delicate one. Each adolescent necessarily seeks to throw off his dependent status by rebelling against parental controls. He is as yet unable to assume all the responsibilities of adulthood and can therefore

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only aspire to gradual emancipation. Too restrictive management will drive him to open rebellion, on the other hand, full freedom is not yet acceptable to him and he will either provoke the re-imposition of adult controls or build rigid authoritative group structures for himself as the study of juvenile gangs shows.

It seems that the regime best suited for adolescents in a residential treatment centre is one of benevolent autocracy. Adult authority becomes acceptable if tempered with liberal measures. It must be firm but friendly. The chief authoritative figure, who is in effect the psychiatrist, imposes an ordered life routine in the unit as well as certain controls, e.g. prohibition to go out without permission or compulsory school attendance, but at the same time he also makes large concessions by allowing for instance unrestricted smoking or late bedtime.

An interesting experiment took place when we tried to introduce group debates by inviting our patients to form their own ward council. We had hoped that group tensions and latent aggression would have been successfully ventilated. The patients elected their own committee and agreed to have a non-voting member from the staff. Topics for debate (such as their opinion on the internal organization of the Unit) were suggested at first with the hope that it would lead our patients to talk about themselves spontaneously as in group therapy sessions. Our experience was different to what we had anticipated. The more assertive members of the group monopolized the debates whilst the rest, particularly the younger patients, remained passive. The debates deteriorated into battles of words between the boys' spokesman and the staff. Demands for more and more privileges were produced with each new meeting. As many of these as possible were granted but when they could not be satisfied this seriously aggravated tension in the group and caused wild diffusion of aggression which had delayed disruptive effects throughout the Unit. We had expected a calmer and more manageable group but instead we found ourselves faced with greater behaviour problems within the group. Eventually the meetings were discontinued and group anxiety decreased.

Many factors were probably at work in making this experiment a failure. If we had persisted the outcome might have been very different and we might have had a more constructive response eventually. So often adolescents act out their past experiences in the present situation and swing between acceptance or rejection of the adult. Hostility follows phases of enthusiasm and co-operation. However, the offer of self-government by a ward council seemed to have been interpreted at the time as a surrender of authority on our part. It caused considerable anxiety in the group. It also created a power vacuum which was exploited by potential group leaders who tried to establish their supremacy over abdicating father figures.

I think the question could well be asked whether a hospital community with its complexities and limitations is the right place for the treatment of disturbed adolescents. Mental hospital regime does not lend itself readily to the particular problems of that age group. Traditionally the excitable or aggressive patient is isolated and restrained or symptomatically treated by means of heavy sedation or E.C.T. The hospital environment is not designed to tolerate much of the aggressive acting out that is so common with adolescence. The attitude of the administration is for a safe group organization and its natural reaction to destructiveness is to demand adequate safeguards. The interests of other hospital departments are at stake just as much as the good name of the hospital in being able to protect the property of our neighbours. For these reasons the environment can never be as simple or free of restrictions as one would like it to be. The danger lies in introducing an atmosphere of

https://doi.org/10.1192/bjp.106.445.1320 Published online by Cambridge University Press

repression and institutionalization for safety's sake, when only the progressive experience of freedom can lead to emancipation and responsible behaviour.

A hospital ward can never become a home. Its contribution must therefore be in short-term adjustment, the emphasis being on providing a therapeutic experience rather than on meeting primary needs in the reality day to day situation. This necessarily curtails our choice of cases, since we cannot take the place of foster parents or offer long-term residential placement to those patients with severe dependency needs. In this respect we can only be of limited value to the bulk of the children who come to the notice of the Children's Department. The disposal of these cases is often difficult and our work is considerably hampered at times by the absence of a suitable half-way house to which our patients could be transferred before they are discharged. A hostel for maladjusted children attached to the unit would serve this purpose admirably. It would provide a suitable environment in which to unload cases requiring long-term residential therapy. It could also be an alternative to those patients whose home situation militates against their adjustment and maturation.

Perhaps one of the greatest drawbacks to the treatment of children in hospital is the absence of continuity of relationships with the nurses. Every eight hours a new shift takes over and the patient is faced with a situation to which he may react as if it were repeated desertion. His attempts to form lasting relationships with adults are constantly being undermined and may lead him to react aggressively against those adults by whom he feels rejected.

Nursing organization in the ordinary mental hospital is planned along rigid traditional lines to suit the needs of a large collectivity. It cannot be substantially modified to fit the requirements of one particular ward. We borrow nurses from the central pool of the hospital and must therefore give them the same conditions of work as in other wards. Nurses cannot be expected to do more than their statutory hours of duty and the idea of their living in with the patients is unthinkable. Yet this would be a distinct advantage and would help to reduce the impersonal atmosphere created by the shift system and the succession of adult figures that this involves throughout the day. According to hospital practice there are two sets of nurses who are alternately on duty. This involves having two charge nurses, a not altogether satisfactory ménage since it causes splitting of authority and provokes various reactions in our patients who are apt to make unfavourable comparisons or play up one charge nurse against the other.

In conclusion I should like to say that for anyone involved in the residential treatment of adolescents, the pressures and demands one must meet in the ward soon become, as Cameron said, "a test of personality". Adolescents quickly put you on your mettle, and greater endurance and emotional maturity are needed than in dealing with other age-groups. As one often hears: "It is bad enough to put up with one's children, who on earth wants to put up with other people's children?" And yet tolerance must govern our approach, there is no place for vindictiveness or regimentation if we are to prove ourselves worthy of our mission, which is to help the disturbed adolescent so often misjudged and misunderstood in our society.

ACKNOWLEDGMENTS

Acknowledgment must be given to the entire staff of Beech House for their help and co-operation in gathering information for this paper. My warmest thanks go to Mr. Clarence Wollen, our male therapist, who contributed largely to the formulation of ideas and observations used in this paper.

https://doi.org/10.1192/bjp.106.445.1320 Published online by Cambridge University Press

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https://doi.org/10.1192/bjp.106.445.1320 Published online by Cambridge University Press