special field alone. The operating is a matter for the surgeon, anaesthetics for the anaesthetist, etc. But a team concept that has built up in psychiatry calls for the whole team operating at the operating site with collective decision-making, etc. We can picture the end result for the patient! A curious element also in the psychiatric team is that the psychiatrist, while apparently no more expert than the rest of the team, claims a medical salary usually considerably higher than that of the other team members. He may claim, "I can give drugs". But this function, in some circumstances, is being claimed also by the nurse and the clinical psychologist.

The term "psychiatrist" is unashamedly iatrogenic and Dr Child, as such, may share the claim to be a "healer of the psyche". If psychiatrists feel their expertise in psychopathology needs improvement then they should concentrate on research and training for medical colleagues leading to increasingly high standards of practice. But to indulge in cosy popularity from less well trained practitioners at the price of exposing patients to lower standards of care is unethical. Patients pay dearly for the multi-discipline, multi-agency practice on all the continents. The Royal College of Psychiatrists has a duty to protect its members and it will neglect these issues at its peril.

JOHN HOWELLS

Hill House
Higham, Colchester
CO7 6LD

Who cares for the adult brain-damaged

DEAR SIRS

Shawcross (1990) described Hamble Ward – a unit for adult brain-damaged indviduals with behavioural problems in Southampton. A similar unit, Heddiw (Welsh for today) Ward, was set up in Whitchurch Hospital, Cardiff in 1988, and has received 40 referrals (20 admissions). Causes for the brain injuries of the admissions include: traumatic head injury (5), cerebrovascular disease (6), Huntington's chorea (4), presenile dementia of Alzheimer type (3), Herpes Simplex Encephalitis Amnestic syndrome (1) and hypoxic brain damage (1).

Thirteen admissions were male and seven female; the age range was 29–70 years (mean for males 54.9, for females 56.3). The time interval from onset of the brain insult/diagnosis to admission ranged from two months to ten years (mean 3.3 years). Referrals were from general psychiatric wards (4), the district rehabilitation unit (2), medical wards (4), and the community (5). A wide range of behavioural problems were seen – depressed mood (5), aggression (6), wandering (5), sexual disinhibition (2), emotional lability (2). Before 1988, the ward was a 16 bedded male ward for the physically frail and offered a homely but custodial environment for patients 51–71 years. This group was an uneasy mixture of long-stay graduates of the hospital and patients with organic brain syndromes from the admission wards. Nursing morale was low as they felt that they were the "dumping ground" of the hospital and, at their request, a planning team was set up and the orientation of the ward changed to a neuropsychiatric rehabilitation unit for people under 65. The aim of Heddiw is a multidisciplinary, problem-orientated approach to treatment (Livingstone, 1990).

Eleven of the first 20 admissions to the unit have now been discharged: fostering (4), home + respite care (6), nursing home (1). The average length of admission is nine months. The bedding accommodation is divided into seven assessment and five respite beds.

Nursing morale has improved greatly since 1988 and, in addition to the in-patient service, the staff act in a consultative capacity to the local rehabilitation hospital. Heddiw fulfils an important need – the neuropsychiatric rehabilitation of young brain damaged individuals showing challenging behaviour – and currently has seven patients on its waiting list for admission.

Should a similar service be provided in every district?

P. L. HUCKLE
M. EVANS
P. WILLIAMS

Whitchurch Hospital
Park Road
Cardiff CF4 7XB

References

LIVINGSTONE, M. G. (1990) Rehabilitation in neuropsychiatry. *British Journal of Hospital Medicine*, **44**, 402–404.

SHAWCROSS, C. R. *et al* (1990) Who cares for the adult brain damaged – Hamble Ward revisited. *Psychiatric Bulletin*, **14**, 526–527.

Do we ride a paper tiger?

DEAR SIRS

I would invite readers to go through the agenda and minutes of the meetings of their Division of Psychiatry over the past 60 months, note the topics brought to discussion, and the decisions reached. Note also the actions taken in response to the decisions, and the time intervals between decisions and actions.

Did you notice a certain pattern? That perhaps the same issues were raised, with little variation and even less action, year after year. Does the monthly

meeting serve a useful purpose? Is its purpose clearly defined? Does it have the power to make anything happen? Why is there a tendency for issues not to be resolved? A friend of mine asked, "Why do we discuss the same things over and over again, with no action ever being taken?" The Chairman asked him to place 'Lack of action on decisions reached' on the agenda for the next meeting!!

A written Constitution of the Division of Psychiatry spells out membership, frequency of meetings, its responsibility, what authority it has, and how it relates to management. Given such definition, the individual Division of Psychiatry becomes a force.

It is perhaps a warning shot that one of the first acts of an outer London, self-governing Hospital Trust was to abolish the Division of Psychiatry!! Those who had been opposed to the Division were very pleased. The others felt that a very useful resource had been lost. Only time will tell.

I. O. AZUONYE

The Royal London Hospital
St Clements
2a Bow Road, London E3 4LL

Treatment of anorexia nervosa

DEAR SIRS

In the light of recent and pending health cuts, I want to make a personal plea to those in the psychiatric profession, who are involved in the treatment of anorexia nervosa, not to opt for cheap short term behavioural or medical interventions in order to save money; or worse, to make money by attracting customers to fast turn-over "feeding units". They may look economical on paper but my own personal experience leads me to believe that they are very expensive in terms of human suffering. Indeed, they are abusive and only serve to compound the problems of most anorexics, whose symptoms are merely the tip of the iceberg and perhaps to them, ironically, their only hold on life. To attempt to remove that hold, with little regard for what may lie beneath, is surely inhuman, ineffective, and hence a waste of money.

I am an ex-anorexic and symptom-free. However, I remember the six years of my illness, beginning in 1971, as a nightmare in which I was subjected to all the treatments available to the medical and psychiatric profession. I list them:

1. six different drugs
2. 20 doses of ECT (in one block)
3. insulin shock therapy
4. hypnosis (plus narco-analysis)

(1–4 were administered during one 6 month admission)

5. heavy sedation (chlorpromazine) plus force feeding (through a tube)
6. the token economy (daily weighings, huge meals, loss of privacy and privileges, bribery and total loss of autonomy).

All these treatments left me worse off; more desperate, depressed and self-destructive. Finally, in 1975 I was admitted to a psychiatric unit, which although not renowned for its eschewing of the medical model, offered me my first real chance of recovery. There I found a psychiatrist/therapist brave enough to view anorexia in its context of a badly damaged personality. He allowed me to gain weight at a rate that I could cope with psychologically, and he listened to what I had to say. He took the responsibility for helping the child inside me keep up and grow with my body. I took the responsibility for eating and keeping myself alive. We worked together for several years. I was an in-patient for 11 months. This was my first successful relationship, and within it I recovered.

It was also my first non-punitive, non-abusive experience of psychiatry.

For many women (and some men) anorexia is an illness stemming from some kind of abuse in childhood. Force feeding, enforced feeding, and harsh regimes only serve to reinforce the idea that the anorexic's body is not her own to control: which is the very idea that may have produced the symptoms in the first place. She, in this last ditch attempt to establish that control, meets with more abuse in the guise of treatment from a supposedly caring professional, a treatment which is symbolically frighteningly close to sexual abuse; with its forced and bribed entries into the body. Once more her trust is abused and her right to control violated.

In my own experience, this kind of regime only seems to reinforce self destructive behaviour, the need to control something of the self becoming more and more desperate until for some, sadly, suicide becomes the only option.

I have survived. That first therapeutic intervention gave me the strength to face up to the cause of my illness. It has been a long haul and I could not have done it had I not been allowed to grow slowly into my adult body and feel safe enough to relinquish the symptoms that hid the underlying problem. It has taken a further 12 years and two more 2 year psychotherapies with another therapist to put together my borderline personality.

It is one thing to re-live childhood abuse with the long-term help of an experienced and trusted therapist, something altogether different to have the cycle of abuse perpetuated by short-sighted authoritarian behaviour therapy. The stream of abused anorexics is not going to dry up overnight. Please consider their future and that of their children and choose a more