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CHAPTER ONE

MULTICULTURAL DIMENSIONS OF PSYCHOLOGICAL TREATMENT

1.1 INTRODUCTION

During the past sixteen years, while working in several psychiatric settings, and while supervising intern-clinical psychologists, in a country undergoing transformation, it has become evident that the skills of psychotherapists need to complement the emerging needs of the multicultural settings in which clinical psychologists work.

Actively working as a consulting psychotherapist in South Africa, for the past twenty-seven years, I have seen how the interactive processes of psychotherapy needed to change, as the nuances of the multicultural realities became more visible. For example, cognitive behaviour therapy as developed by Beck (1976, 1995) and described by Hollon and Beck (1994, 2004) is often an excellent choice of psychotherapy for problems relating to depression, anxiety, and panic attacks, for people living in First World communities. However, when family members who present with symptoms associated with depression, anxiety, and panic attacks, and are also struggling to meet their basic needs as described by Maslow (1968), the psychotherapist has to often, act first as a mediator and facilitator, to help the family members address and satisfy their basic needs, like nutrition and sanitation, before formal and effective psychotherapy can be implemented.

Regarding research on psychotherapy with culturally diverse populations Sue, Zane and Young (1994) stated more than thirteen years ago that if "…*current treatment practices work well only with certain populations, we need to know about these limitations and devise strategies to address the mental health needs of culturally diverse groups*" (p. 783) . In the same vein Zane, Nagayama Hall, Sue, Young and Nunez (2004) sum up their discussion on research on therapy with culturally diverse populations by stating: "*Probably the most challenging issue for ethnic mental researchers has been the development of viable strategies*

for specifically examining the role of culture in psychotherapy process and outcome" (p. 796).

In order to investigate the many influences and dimensions that shape a psychotherapist's repertoire of skills in order to effectively understand and meet the needs of patients in a transforming multicultural setting**,** *two* aspects became apparent. The *first*, being the need for a theoretical model which would accommodate as many aspects of psychotherapy as possible. The *second,* being the need for a research method, flexible enough to allow sufficient room for each possible influence and dimension, to be inquired into, and explored adequately. The *Ecosystemic psychotherapeutic model* was considered to be the appropriate theoretical model while the *Ethnographic research method* was considered to be the most suitable method to deal with the research aspects. The Ethnographic research method and the Ecosystemic psychotherapeutic model will be discussed more comprehensively in Chapters 2 and 3 respectively.

It will become evident in the forthcoming chapters how the psychotherapeutic theories, models, and strategies related to multicultural issues (Brooks-Harris, 2008; Brooks-Harris & Gavetti, 2005a, 2005b, 2008; Corey, 2000, 2001, 2005; Moodley & Palmer, 2006; Valdez, 2006), are compatible with the ecosystemic and ethnographic dimensions which permeate this study. Firstly it is necessary to consider the multicultural influences and dimensions that typically play a part in a psychiatric hospital.

1.2 MULTICULTURAL DIMENSIONS OR INFLUENCES THAT PLAY A PART IN A PSYCHIATRIC HOSPITAL

1.2.1 Culture and Multicultural

The term *multicultural*, includes, but is not restricted to class, language, ethnic background, or racial heritage only. In the context of anthropology *culture* may be defined as "…*the shared behaviour learned by members of a society*" (Beals & Hoijer, 1971, p. 677). A person's culture tells the person *what may be done*. For example, what they may eat, how they should dress, and how they should behave in specific contexts.

Within the context of *multicultural* counseling and psychotherapy, Corey (2001) states that "*Culture is, quite simply, the values and behaviours shared by a group of individuals. It is important to realize that culture does not refer just to an ethnic or racial heritage but includes age, gender, religion, education, sexual orientation, physical and mental ability, and socio-economic status*" (p. 26).

In the context of *culture, healing, and psychotherapy* Gielen, Fish and Draguns (2004), describe culture as *"…the part of the environment that has been generated or created by human beings*…[that]…*encompasses concrete, visible, and tangible products created by human action, as well as …the systems of communication and the preserved experience of prior generations, and also the shared values and beliefs that, at the same time, represent templates for future action…it is reasonable to expect that cultures have shaped the healing and psychotherapeutic practices that have evolved within them*" (p. 1).

Gielen et al's. (2004) definition highlights the following aspects:

- an environment that has been generated or created by human beings;
- systems of communication;
- preserved experiences of prior generations;
- shared values and beliefs;
- templates (patterns) for future action and;
- healing and psychotherapeutic practices that have evolved within the culture.

In the present study *culture* is seen from an ethnographic perspective, meaning that all aspects of a particular culture which are manifested are relevant when members in a particular culture participate in a *culture-sharing group*. An ethnographic researcher sees *culture at work* and can provide a description and interpretation of what s/he observes and experiences when interacting with members of the culture-sharing group. The *culture at work* or the sharing of the same culture is seen in all aspects of the participant's behaviours, for example language, mannerisms, rituals, traditions, customs, ways of life, and artefacts (Creswell, 1998).

Multicultural thus refers to all aspects of a person's personal upbringing in all environments in which s/he has been exposed to. *Multicultural* thus also refers to the different viewpoints and epistemological approaches in understanding people of different backgrounds. In turn,

Multicultural psychotherapy refers to the therapeutic interventions, developed and generated, from the understanding of the social structures in which the individual lives, which provides mental health, including sexism, racism, ethnicity, religious belief and other forms of oppression and privilege which impacts on a person's development and personality (Corey, 2005). Multicultural psychotherapy also refers to, and includes the understanding of the social structures, and the therapeutic interventions appropriate to, and for, refugees and immigrants.

Taking into account all of the above aspects of culture, psychotherapy, and healing, the culture-sharing group of a psychiatric hospital will now be explored. Psychiatric hospitals have often been described as, *therapeutic communities, health-care centres, institutions, nerve clinics*, and *rehabilitation centres*, with distinct *sub-cultures* of their own, depending in which country and location they are situated (Jones, 1968).

Although all helping professions are related, in the sense that they have the same goals and objectives in achieving and ensuring the mental health of the patient, as well as creating a culture of rehabilitation, there are however distinct roles, responsibilities, length, depth and intensity of the training that each mental health professional undergoes. Each profession has its own framework and culture in which it works within the broader system of the psychiatric hospital. Each subsystem, in each hospital system, ranging from the mental healthcare subsystems, to the administrative subsystems, has its own culture, with its own way of doing things**.**

The following multicultural professions typically play a part in a psychiatric hospital in South Africa.

1.2.2 The Culture of the Clinical Psychologist Subsystem

Clinical psychologists are trained psychotherapists who use their psychotherapeutic skills to assess, evaluate, diagnose, and treat people who experience emotional problems.

The training of a clinical psychologist includes five years of academic training (four years pre-graduate and two years post-graduate), one year's internship at an accredited psychiatric institution, and the submission of an acceptable research dissertation, after which the

individual registers as a clinical psychologist at the Health Professionals Council (formerly referred to as The Medical and Dental Council). Internships are limited and the potential candidates undergo a stringent selection procedure before they are accepted into the Masters programme at the beginning of their postgraduate studies.

In a psychiatric setting, clinical psychologists are typically involved with clinical assessment, psychometric testing and with all aspects of psychotherapy (short and long term individual, group, couples and family psychotherapy). The culture of the psychologist focuses on *care* and *tota*l patient management, rather than on cure. It is interesting to note what Jung (1963) observed in 1909, when he stated that, "*Already at the beginning of the century I treated schizophrenia therapeutically…it did however take a long time before people began to introduce psychology into psychiatry*" (p. 149).

1.2.3 The Culture of the Psychiatrist Subsystem

Psychiatrists are not necessary trained as psychotherapists in South Africa. Psychiatrists are qualified medical doctors who specialise in the field of psychiatry by undergoing a four year registrarship in a psychiatric hospital. The emphasis of their training is placed on the psychiatric aspects of medicine and diagnosis. In a psychiatric setting, psychiatrists are mainly involved in heading multidisciplinary ward rounds, and prescribing and monitoring medication. In South Africa, psychiatry has for a long time been strongly imbedded in the medical model, also referred to as the biomedical model in which much emphasis is placed on the physical remedies, such as psychopharmacotherapy, ECT (electro convulsive therapy), light therapy, drug assisted interviewing, and psychosurgery (Roos, Joubert & Stein, 2001). This model is very much in line with Benjamin Rush's conviction of the organic nature of insanity (Freedman, Kaplan & Sadock, 1976). Benjamin Rush (1745-1813) who is the undisputed father of American psychiatry can be seen on the seals of all the American Psychiatric Association publications of the DSM (APA, 2002; Freedheim, 1992, p. 302, footnote 7). The biomedical model has a history of restricting healing to purely physical phenomena on the physical dimension in the healing process. Within the context of the evolution of psychotherapy, Szasz (1997) reminds clinicians that "*In the eighteenth century, Western societies began to delegate to mad-doctors—subsequently called alienists, psychiatrists, mental health professionals, and therapists—the task of separating insane*

people from sane people and incarcerating the former in mad-houses" (p. 301). In a similar vein Capra (1982, pp. 126-127) reminds his readers that although the word psychiatry has its root in the Greek word *psyche* (mind) and *iatreia* (healing), psychiatrists have concentrated their efforts on finding organic causes, such as infections, nutritional deficiencies, and brain damage for all mental disturbances, rather than trying to understand the psychological dimensions of mental illness.

In recent years however, in the context of psychiatry there has been a shift towards a biopsychosocial or systemic approach, in which psychosocial interventions are combined with the physical treatments (Baumann, 2007; Roos, et al., 2001). Expanding on this aspect, Roos et al. (2001) contend that: "*There is growing evidence that in the majority of cases, combined physical and psychosocial interventions are more effective than physical treatments alone*" (p. 445), and that psycho-education has become a requirement in all treatment interventions, including in the treatment of schizophrenia, in which psycho-education has been shown to significantly lower the relapse rate. In the same vein Baumann (2007) asserts that the biomedical model is insufficient and that a broader and more flexible approach be adopted. "*The emphasis shifts from the underlying cause to the context, from the pathogen to the person, in a particular environment*" (p. 13).

Reflecting on his own personal psychiatric activities, Jung (1963) concedes that "*Clinical diagnoses are important, since they give the doctor a certain orientation; but they do not help the patient. The crucial thing is the story. For it alone shows the human background and the human suffering, and only at that point can the doctor's therapy begin to operate*" (p. 145).

1.2.4 The Culture of the Psychiatric Nurse Subsystem

A four year diploma in general nursing, during which psychiatric nursing is taught in the third year, or a three year University degree is required. In a psychiatric institution the role of the psychiatric nurse is mainly to attend to the patient's physical needs, like meals, medication, physical hygiene, and the administration of ward routine. Besides the many administrative duties, psychiatric nurses also attend the multidisciplinary ward rounds during which they report on the patient's behaviour as observed in the ward. Sometimes the nurses attend the ward climate meetings and group therapy sessions, and facilitate in ward activities for the

patient's well being, and for the patient's overall rehabilitation. In South Africa (Uys, Pietersen & Middleton, 1994) psychiatric nursing responsibilities appear to be in line with the USA standards and philosophy as outlined by Stuart and Laraia (2001). For example, because the psychiatric nurse is involved with the patient over a very wide field and is in continual contact with the patient, the nurse's *main concern* should be on the patient's *total functioning*. Many nurses, although highly trained as therapists and health educators, are considered merely assistants of doctors, and can rarely use their full potential. It is interesting to note that in a study by Norcross and Freedheim (2003, p. 885), psychiatric nurses are forecasted to be the second most effective group of *future service providers* of psychotherapy in the U.S.A.

1.2.5 The Culture of the Social Worker Subsystem

A four year degree at a University is required. No academic or practical training is done in psychotherapy during their training. The social worker's role generally revolves around conducting a psychosocial assessment of the patient, placement in the community or in another institution, and collecting collateral information. A *biopsychosocial* stance is normally adopted in the social workers assessment and aim towards rehabilitation of patients. This means that the biological, psychological, and social factors of the patient are incorporated into the social worker's assessment and recommendation towards the patient's total rehabilitation. As is the case with the psychiatric nurses and the occupational therapists, the social worker is given great responsibility, but without any authority to take the lead in making rehabilitation decisions when non-medical decisions are to be made. Any decision has to be strongly motivated and approved of, by the consultant psychiatrist (T. L. Mathole, personal conversation, March 14, 2005).

1.2.6 The Culture of the Occupational Therapist Subsystem

The occupational therapist's academic training spans over four years which includes one year practical orientation and exposure to a psychiatric setting. The fundamentals of psychology and group training are taught for two years. The role of the occupational therapist is to assess and evaluate all referred patients, and to refer patients to appropriate treatment programmes. Their role is also to establish treatment aims for the therapeutic groups according to the needs of the patient, and to plan individual and group activities according to the aims of treatment.

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Additionally, the occupational therapist gives regular feedback to other multidisciplinary team members, on the patient's participation, and also co-ordinates ward programmes. The occupational therapist focuses on the *total functioning* and well-being of the patient, taking into account the patient's biological, psychological, social, and occupational abilities (Breet, 2004). The occupational therapist helps immensely in the total rehabilitation of the patient, but does not have the legal authority to function more independently. For example in the absence of a consultant, practical decisions cannot be made which often leads to increased patient frustration, often interpreted as relapse or negative behaviour, which subsequently results in unnecessary hospitalization, institutionalization, and medication.

1.2.7 The Culture of the Pastoral Care Subsystem

Pastoral care addresses the patient's spiritual/religious needs and concerns, in which there should be no discrimination towards the patient's spiritual and religious values. Pastoral care is also not advocated from any particular religion or denomination. Rather, the patient's own faith perspective which shapes the patient's personal beliefs, attitudes, and practices is sought to be understood by the qualified pastor. Closely related to the culture of the pastoral care subsystem are the dimensions of *spiritually oriented psychotherapy* (Sperry, 2001; Sperry & Shafranske, 2005), *psychotherapy and religious diversity* (Richards & Bergin, 2000; Weiner, Cooper & Barbre, 2005) and *transpersonal psychiatry and psychology* (Scotton, Chinen, & Battista, 1996), which is gaining increasing sympathy among practitioners (Blatner, 2005), and will be referred to, and discussed in more detail in the following chapters.

1.2.8 The Culture of the Food and Nutrition, Sanitation, and Infection Control, Subsystems

Nutrition, personal and public hygiene are necessary before any psychoactive drugs or any psychotherapy can be of any therapeutic use. A balanced diet and adequate nutrition strengthens a person's response to his/her organism's resistance to infectious diseases. For example chicken pox, syphilis, and the HIV virus are common in many psychiatric hospitals in South Africa. The importance of the work carried out by dieticians and infection control officers are not always realised, acknowledged, and appreciated by patients and staff alike. In a multicultural setting, patients often request or demand their *traditional diet*, meaning

mealie porridge, brown bread and cheese, *not*, samp, white bread and yogurt, or any other combination thereof. Nutrition and sanitation may be seen in the context of *behavioural health*, a sub-speciality of behavioural medicine (Bell, 2002; Phares, 1988; Schlebusch, 1990), which focuses on health maintenance, health enhancement, and disease prevention, which forms part of the integrated health care philosophy of the multidisciplinary team.

1.2.9 The Culture of the Security Subsystem

The security personnel play an important part in providing an image of order, stability, and protection in the hospital. Dagga infiltration and peddling has been an ongoing major problem in psychiatric hospitals. Dagga and alcohol is brought in by staff, visitors, and by those patients coming back from day passes or leave of absence (LOA). The motive seems to be, to earn extra money for the individuals doing the trafficking. However, since the newspaper article in February 2005 (Van der Bliek, 2005), cameras and a private security company have been implemented at Weskoppies Hospital. Cameras have been positioned in strategic places in the hospital grounds to monitor the activity of all people's movements.

1.2.10 The Culture of the Multidisciplinary Team Subsystem

The *multidisciplinary* team also sometimes referred to as an *interdisciplinary* team typically consists of a specialist psychiatrist, a psychiatric registrar, a specialist clinical psychologist, an intern-clinical psychologist, a social worker, an occupational therapist, and a psychiatric nurse.

The function of the multidisciplinary team is to make rehabilitative decisions in the patient's best interest, within the parameters of the hospital's policy and in accordance with the country's existing Mental Health Act (The New Mental Health Care Act, No 17 of 2002).

Multidisciplinary ward rounds are run in many different ways by women and men with different personalities, attitudes, beliefs, and professional training. It stands to reason that the culture and atmosphere of each multidisciplinary team differs with respect to how the different personality characteristics of each member of the team impacts on the interaction and decision making process of the patient's total rehabilitation. For example, the different professional team member's interviewing skills, elicits different responses and information

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gained from the patient. Also, each team member attaches different meanings and importance to the concepts of rehabilitation, clinical diagnosis, relapse prevention, behaviour modification, patient compliance, to name a few of the aspects that the multidisciplinary team members have to discuss and reach consensus on.

The task of the interdisciplinary team is to focus on *total patient management*, in which all aspects of the patient's functioning are considered. What is true for the prevention of illness is also true for the art of healing the mentally ill. In both cases the health professional has to deal with the *whole individual* and the relation to the physical, emotional, and social environments. In the multidisciplinary context, an integration of the *intrapsychic* (body and mind), and the *interpsychic* (interpersonal and intercultural), aspects of the patient's functioning, needs to be understood, when deciding upon the patient's rehabilitation process.

1.2.11 The Culture of the Hospital System as defined by the New Mental Health Care Act

The hospital of course is a subsystem of the larger community and of the Regional and National government. In South Africa, The New Mental Health Care Act No.17 of 2002 emphasises the prohibition against unfair discrimination of people with mental and other disabilities. Also the emphasis focuses on de-institutionalization and de-hospitalization of patients. Attempts are made to get the patient back into the community as soon as possible. The *constitutional* rights and responsibilities of the patient need to be considered in the patient's total rehabilitation. The National Action Plan for the Promotion and Protection of Human Rights, commonly known as *The Constitution of South Africa* (1998) clearly spells out the human rights of the people of South Africa in an international effort to promote and protect human rights globally.

According to Corey (2000), "*Being able to deal effectively with institutional demands and policies may at times be as important as being professionally competent*" (p. 37). Working in an institutional setting, continually presents a struggle between, retaining the patient's dignity and integrity and the administrators concern about custodial care. Administrators are generally indifferent to the genuine attempt of achieving an effective therapeutic outcome.

The concept of the therapeutic community as described by Jones (1956) is a practical and achievable ideal, which implies that the responsibility for treatment is not restricted to the health professionals only, but is a responsibility shared by all other community members including the patient's themselves. Foudraine (1974) has described how he has initiated the basic principles of a therapeutic community in the USA as well as in the Netherlands in the 1960's, with much resistance but with good results.

1.2.12 The Culture of the Patient's Support System or Family

In South Africa the male and female population, speak one or more of the eleven official languages; belong to one of the numerous religions and; belong to either the Black, White, Asian, or Coloured racial groups. Some members, while sharing different languages, ethnic backgrounds and skin tone, however share a common religious belief. Depending on the individual's upbringing and personality development, will determine which dimension of the aforementioned aspects the person makes a priority in his or her life decisions. For example when it comes to marriage, then the family and traditional values of a person's culture may subsume his/her religious beliefs, or visa versa.

It also sometimes happens that when a patient goes home on leave of absence (LOA), s/he is expected to partake in the community member's practice of traditional medicines, traditional beer, and the usage of cannabis, influencing the patient to abandon his/her prescribed medication, resulting in a relapse.

In an internal circular, issued to all mental health hospitals in the province of Gauteng, South Africa on 05-04-2002, it was emphasised that in the treatment of psychiatric patients "… *the goal remains rehabilitation and return to the care in the community. In this regard, the family has a central role*" (Lazarus & Thom, 2002, p. 1).

1.3 THE HEALTH CARE PROFESSIONAL AS A THERAPEUTIC PERSON

The major advantage of working in a multidisciplinary team is that if one or even two members are absent from a ward round, then the other team members are still able to assess

and make the necessary interventions for the patient's total functioning. However, each health care professional in the team needs to effectively reflect the therapeutic nature of the total team's attitude towards mental health care. All team members need to become "psychologized" and "therapised" themselves. Moreover, the institution needs to become therapised, rather than the therapy or treatment becoming institutionalised. More of this later.

The cornerstone of any therapeutic relationship is to establish *a working relationship of trust with the patient.* Techniques, interventions, and strategies cannot be effective and long-lasting, if there is no relationship of trust. The art of healing cannot be quantified, nor does it necessarily depend on academic qualifications. Only in an atmosphere of openness, trust, caring, understanding, and acceptance can the art of healing become a reality. Some healthcare professionals seem to make people well while others regardless of their expertise, status and academic qualifications, have high rates of complications.

Corey (2005) identifies the following sixteen practical issues that beginning therapists need to be aware of, who wish to sensitize and sharpen their therapeutic effectiveness in multicultural therapeutic settings. Although meant for beginning counsellors and psychotherapists, the following issues are frequently experienced to a greater or lesser extent by all mental health professionals in their work environment:

- Dealing with our anxieties.
- Being and disclosing ourselves.
- Avoiding perfectionism.
- Being honest about our limitations.
- Understanding silence.
- Dealing with demands from clients.
- Dealing with clients who lack commitment.
- Tolerating ambiguity.
- Avoiding loosing ourselves in the client.
- Developing a sense of humour.
- Sharing responsibility with the client.
- Declining to give advice.
- Defining your role as a therapist.
- Learning to use techniques properly.

- Developing your own counselling style.
- Staying alive as a person and as a professional.

1.4 PSYCHOTHERAPY

The emphasis of this thesis focuses on the effectiveness of psychotherapy, specifically the way in which psychotherapy has become aligned to multicultural settings. It thus becomes necessary to discuss the main principles, tenets, and underpinnings in the development of psychotherapy, which will be outlined in Chapter 3. The different therapeutic approaches are discussed in Chapter 4.

1.5 ETHNOGRAPHIC RESEARCH

Ethnography may be defined as the study of an *intact* cultural or social group based mainly on *observations* over a *prolonged period* of time in which the researcher is a *participant*. The ethnographer *observes and listens* to all informants with the intent of generating a *cultural portrait*. A cultural portrait refers to a holistic view of the culture-sharing group which is the final product of the research in all its complexity (Creswell, 1998; Hammersley & Atkinson, 1995; Thomas, 1993).

According to Neuman (2000) *ethno* means people or folk while *graphy* refers to describing. Ethnography refers to the study of people in their natural context or setting. Observing and interacting with people in their natural setting and everyday contexts, rather than under traditional research experimental conditions created by researchers, affords more spontaneity and less guardedness on the part of all persons involved. The researcher becomes a natural and accepted participant of all interactions of which s/he is a part, and which s/he witnesses. Ethnography thus also refers to the understanding of a group of people interacting in a specific place, according to their everyday way of life (Creswell, 1998; Ellis & Bochner, 2000; Hammersley, 1990; Neuman, 2000; Wolcott, 1988).

Since 1992 I have been a member of a multidisciplinary team, instrumental in the treatment and rehabilitation of patients, resident in a psychiatric hospital setting. During this time

period, I have also been a member of a selection panel, and a supervisor, for intern-clinical psychologist at the following accredited training institutions:

- Garankuwa Hospital (presently renamed Dr. George Mukhari Hospital) from 1992 to 1994.
- Westfort Hospital, from1994 to 1997.
- Weskoppies Hospital, from 1997 to the present time 2008, during the completion of this thesis.

Thus, for the past sixteen years I have been both, a participant and an observer for the inquiry into the present study.

A comprehensive outline on ethnography and how ethnographic research was conducted in the above workplaces will be given in the Chapter 2.

1.6 MOTIVATION

1.6.1 The Problem Statement

The source which inspired and gave rise to the need for the present study may be summed up in the following two research questions:

- *"Is the present way of treating and rehabilitating patients in a psychiatric hospital the most therapeutically effective method of rehabilitation and of treatment in multicultural settings?"*
- *"Are intern-clinical psychologists receiving adequate and relevant training and supervision when working with culturally diverse populations?"*

1.6.2 Why is This Study Needed?

The present study is an attempt to make a spontaneous and non-threatening inquiry into the present contexts in which patients are treated at Weskoppies Hospital. The *need* for the present study and the *source* which triggered the motivation is based on the following:

- In my own *personal experience* I have seen the need to upgrade therapeutic programmes in the training hospital settings in which I have worked.
- The *media coverage and negative publicity* of psychiatric institutions, generally, including Westfort and Weskoppies hospitals, has sparked much debate on personal, local, provincial, and governmental levels (Adams, 2004; Christoforakis, 1997; Cullinan, 2006; Foudraine, 1974; Goffman, 1961; Hosken, 2006a, 2006b; Motale & Sapa, 1996; Nthite, 2004, 2006; Nthite, & Du Plooy, 2006; Otto, 2005, 2006a, 2006b, 2007a; Peete, 2005; Smetherham, 2004; Van der Bliek, 2005; Venter, 2006a, 2006b, 2006c, 2006d, 2006f, 2006g).
- Work related problems, in the context of a country which has undergone a rapid political transformation and still in transition, while lagging behind in social, psychological, and economic dimensions (Caelers, 2005a, 2005b; Sparks, 2007; Staff Reporters & Reuters, 2006).
- It is commonly observed that political and budget influences and priorities supersede therapeutic priorities and decisions (De Ionno, & Mokopanele, 2007; Hosken, 2006c, 2006d; 2007a, 2007b; Webb, 2007a, 2007b, 2007c, 2007d).
- Multicultural issues are presently in the global *research agendas* and literature arenas (Corey, 2000, 2001, 2005; Lambert, 2004; Moodley & Palmer, 2006, Multicultural Psychotherapy Associates, 2004, 2006).

1.6.3 Why Ethnography?

Ethnography is one of several traditions within qualitative research.

According to Creswell (1998) all traditions of qualitative research requires *a strong commitment* to inquire into a phenomenon, and requires *time* and *resources.* As will become evident during the unfolding of this thesis, the present study fulfils the following criteria as set out by Creswell (1998). The researcher needs to be willing:

- To commit himself/herself to extensive time in the field.
- To engage in the complex, time-consuming process of data analysis, this is then reduced to a few themes or categories.
- To be able and willing to write long passages, because the evidence must substantiate claims and the researcher needs to show multiple perspectives.

- To participate in a form of social and human science research that does not have firm guidelines or specific procedures and which is constantly evolving and changing.

Neuman (2000) states that field research is"… also called *ethnography* or *participation-observation research*" (pp. 344-345). In response to Neuman's (2000) question of *"What do field researchers do?"* (p. 350), the present thesis also fulfils the author's following ten activities and attitudes:

- The observation of everyday events and everyday activities as they happen in natural settings, in addition to any unusual occurrences.
- The direct involvement with the people being studied and personally experiencing the process of daily social life in the field setting.
- The acquisition of an insider's point of view while always maintaining the analytic perspective or distance of an outsider.
- The use of a variety of techniques and social skills in a flexible manner as the situation demands.
- Producing data in the form of extensive notes, as well as diagrams, maps, or pictures to provide very detailed descriptions.
- Sees events *holistically* (for example, as a whole unit, **not** in pieces) *and individually in their social context*.
- Understands and develops empathy for members in the field setting, and does not just record "cold" objective facts.
- Notices both *explicit* (recognises, conscious, spoken) and *tacit* (less recognised, implicit, unspoken) aspects of culture.
- Being able to observe ongoing social processes without upsetting, disrupting, or imposing an outside point of view.
- Being able to cope with high levels of personal stress, uncertainty, ethical dilemmas, and ambiguity.

1.6.4 Why the Ecosystemic Psychotherapeutic Approach?

The motivation for choosing the ecosystemic approach is based on the following rationale:

- The ecosystemic approach, as described by Von Bertalanffy (1966) expanded by Watzlawick, Beavin & Jackson (1968) and developed and refined by numerous ecosystemic thinkers and practitioners (Barlow, 2003; Fourie, 1998; Peters, 2003; Phipps, 2004; Swart & Wiehahn, 1979; Venter, 2004; Vorster, 2003), is the theoretical paradigm which has been used for training clinical psychologists at the Medical University of Southern Africa (Medunsa) since 1994. However, since 2005, the theoretical emphasis in the clinical psychology training course has shifted to the integrative and transtheoretical models. The integrative approach seeks the best approach to psychotherapy that each therapy model has to offer, in line with what is proposed by current authorities such as, Bergin and Garfield (1994), Corey (2005), Lambert (2004), and Prochaska and Norcross (1999, 2003, 2007).
- The ecosystemic approach to psychotherapy, (based on general systems theory), is an *epistemology* (the study of how we know) and is applied as a *meta-theory*. This means that the ecosystemic approach provides a foundation which subsumes all aspects of all traditional psychotherapies. It provides both the foundation and the umbrella that accommodates all aspects of traditional psychotherapies.
- Unlike any one particular psychotherapeutic model, the ecosystemic approach takes into account *all* the interrelated and interdependent systems in which an individual functions. The intra-psychic as well as the inter-psychic (interpersonal and socio cultural) aspects of an individual's behaviour and experiences are given equal significance.
- The therapist and the client are regarded as being of equal importance. According to Phipps's (2004) investigation and development of systems therapy, the client's subjective report of her/his ongoing experiences guides the clinician in the clinician's choice of interventions as the therapeutic relationship develops. The client is thus regarded to be an expert in describing and reporting her/his ongoing subjective experiences. The clinician is also regarded to be an expert with regard to her/his trained observation and listening skills. It is evident that the objective (expert, absolute) skills of the therapist as well as the subjective (post-modern, relative) experiences of the client are taken into account.

1.7 OBJECTIVES AND AIMS

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The central thrust, (purpose, intent, aim) of this ethnographic study is to explore and inquire into the many psychological influences that play a part in the treatment and rehabilitation of persons afflicted with mental illness, and who are resident in a psychiatric hospital. A related objective is, to create awareness, and to establish dialogue, amongst mental health professionals in order to utilize and optimize our therapeutic skills for the patient's best advantage, and for the patient's best interest.

In summary, the *research question* asked and the *problem and purpose statement* made is:

"What is the most effective way of treating residents in a multicultural psychiatric hospital, and how should psychologists be trained to bring about the desired outcome?"

The *objective or intent* of this study is to explore the multicultural influences that play a part in the psychological treatment and training of health professionals in a psychiatric setting; the *method used* will be an ethnographic approach.

1.8 PRESENTATION

Chapter one has described the twelve subsystems (subcultures) within the culture of a hospital like Weskoppies Hospital. Some brief guidelines for all health care professionals, to enable us to remain as therapeutic persons, are outlined in Section 1.3. Finally the motivation and aims of contextualizing the study in an ethnographic and an ecosystemic framework, are given.

Chapter two firstly distinguishes between qualitative and quantitative research, and then outlines a detailed exposé of ethnographic research, drawing from several authorities in the field, and finally relating to how it was applied in the present study.

In Chapter three, all the fundamental and relevant aspects of psychotherapy are discussed, including the International, Eurocentric and Afrocentric aspects. The ecosystemic and group psychotherapeutic approaches are dealt with in more detail.

Chapter four describes the theoretical perspectives of treatment and training that students are initiated into, in the culture of therapeutic psychology.

The format of Chapter 5 reflects the style of the art of ethnographic *writing* illustrated by Ellis and Bochner (2000), while describing the culture-sharing group of the hospital in general.

Chapter six describes the culture-sharing group of Ward 59 (an open ward).

In Chapter seven the culture-sharing activities of a semi-closed (Ward 65) and a semi-open (Ward 66) ward are inquired into.

Activities of the culture-sharing groups in the maximum security wards (Wards 22 and 23 are inquired into, in Chapter eight.

Chapter nine inquires into aspects related to understanding the patient in the multicultural context.

Conclusions, recommendations, and the implications of the study are presented in Chapter ten.

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CHAPTER TWO

METHODOLOGY

2.1 INTRODUCTION

In this chapter I will emphasise and contextualise key concepts, principles, and assumptions of research methods in general (Sections 2.2 and 2.3). I will then elaborate on the tradition of ethnographic research with relevance to the present study (Sections 2.4, and 2.5).

To put the reader in context of how ethnographic research fits into the framework of all other types of research, I will present general outlines of *qualitative* and *quantitative* research approaches in the following two sections. These approaches used by researchers to investigate a particular system that is under inquiry, have distinct characteristics which distinguish them as being different research paradigms.

2.2 QUANTITATIVE RESEARCH

In quantitative research, *control* and *prediction* of variables takes precedence by means of *measurement* and q*uantification*.

Quantitative research starts with the inquirer's predetermined hypothesis which is to be tested and finally either confirmed or refuted. Subjects, also referred to as participants, are selected and are recognized as representative of a cross-section of the relevant population. The sample size must be proportionately large and representative to be valid. Sometimes a hypothesis is tested by subjecting experimental groups and control groups to different values of an independent variable, in order to determine what effect this variation has on the dependent variable. This kind of inquiry is useful for statistical purposes, such as population audits, and for predicting future trends in the fields of economics, finance, politics, and the natural sciences. It is also functional to develop a theory (Capra, 1982; Kerlinger, 1975; Neuman, 2000; Zuber-Skerritt, 2000).

Clearly this present study does not fit into the paradigm of quantitative inquiry. The present study grapples with the complexity of cultural influences and treatment of residents within a psychiatric institution. *Qualitative inquiry* therefore becomes the appropriate paradigm within which to work in the present study.

2.3 QUALITATIVE RESEARCH

In contrast to quantitative research in which *control* and *prediction* of variables, takes precedence by means of *measurement* and q*uantification*, in qualitative research *meaning* and *significance* of *themes* takes precedence by means of first-hand *experiencing* and *participating*. According to Creswell (1998) "*The researcher builds a complex, holistic picture, analyses words, reports detailed interviews of informants, and conducts the study in a natural setting*" (p. 15).

The key difference between quantitative and qualitative inquiries is that quantitative researchers work with a few variables or influences and many cases, whereas qualitative researchers rely on a few cases and many interacting variables or influences (Creswell, 1998).

The following traditions are some of the more well known methods found within the paradigm of qualitative research.

2.3.1 Case Studies

A case study usually refers to an intensive study of the individual. It is typically an in-depth investigation about one person's functioning, and an attempt is made to understand an individual in his or her complexity and uniqueness. Case studies have been particularly useful in the field of clinical psychology in the context of psychotherapeutic treatment (Kazdin, 1980).

2.3.2 Biographies

In biographies, the *experiences* of *a single individual,* provides the central focus of the study. Data collection consists of *conversations* which are focused on the experiences as told by the

subject to the researcher, and/or information obtained from *documents* and *archival materials,* and/or observation participation (Creswell, 1998).

2.3.3 Phenomenological Studies

The personal *experiences* of several individuals, and the subjective *meaning* it holds for those individuals, about *a single phenomenon,* is the central focus of phenomenological studies. The single phenomenon studied, for example, individuals who have personally experienced the phenomenon of a natural disaster, or an unjust political system, is based on the phenomenological principles embedded within an accepted philosophical school of thought related to the phenomenon being investigated (Creswell, 1998).

2.3.4 Grounded Theory Studies

Grounded theory begins with a research question relating to individuals responding to a particular problematic or challenging situation. Grounded theory has established the notion, that *theoretical knowledge* can be *generated from* specific contextual information, and data collected from people within a particular context like an organization, group, or culture. The information and data is collected from an inside viewer who participates within the group, organization, or culture being studied. Thus, knowledge and theory become personalized, relevant to, and fully integrated into the inquiry process (Neuman 2000; Zuber-Skerritt, 2001). The focus is therefore on generating a theory which is grounded (embedded) in the data that was collected (Creswell, 1998).

2.3.5 Action Learning and Action Research

The phrase ‘action research’ was coined by Kurt Lewin, which describes the group decision making process in terms of *planning, fact finding*, and *execution* towards solving a problem (Carr & Kemmis, 1986). According to Zuber-Skerritt (2001) action learning and action research (ALAR), consist of approaching a problem by selecting principles borrowed from certain theories, and are then *integrated* into a new theoretical model. For example, principles from *grounded theory* (Glaser & Strauss, 1967), *personal construct theory* (Kelly, 1955), *critical theory* (Carr & Kemmis, 1986), and *systems theory* (Marquardt, 2000) are used to

inquire into the problem being explored, with the aim of solving the problem. According to Thomas (1993) the action researcher opts for *relevance* when approaching the problem, and identifies closely with *the needs and concerns of the subjects*, using diverse theoretical perspectives in bringing about a practical solution.

2.3.6 Ethnography

Ethnography has much in common with all aspects of the five above types of research approaches. Because of its flexible nature, ethnography is not restricted to any one particular set of research rules, principles, or presuppositions. At the same time ethnography may use any of the rules and guidelines belonging to both the qualitative and quantitative research paradigms.

An introductory outline of ethnography has already been given in Sections 1.5 and 1.6.3 of Chapter One. By sometimes referring to aspects in these sections all relevant aspects of ethnography will now be discussed in detail in the following section.

2.4 ETHNOGRAPHIC RESEARCH

Ethnography has been the standard research method used by social and cultural anthropologists since the early decades of the twentieth century. For example, in the 1920's and 1930's sociologists came to view the rapidly expanding Chicago (USA), as a natural laboratory in which "*… the diversity and processes of change characteristic of human behaviour could be studied*" (Hammersley 1990, p. 3). On the basis of observation and participation, key aspects of Chicago's inhabitants, which included the steady inflow of the new European immigrants, were studied according to "*... methods that approximate the ethnography of today*" (p. 3). Denzin (1997), Denzin and Lincoln, (2005), and Lincoln and Denzin (2000) give a critical account of how ethnography has developed since 1900. The authors states that in 1995 we moved from the fifth to the sixth historical moment of ethnographic history. By 2000 we had moved into the seventh and eighth moments of ethnographic history which are characterised by uncertainty on the one hand, and by the adventure of new methodologies, research practices, and epistemologies on the other hand

2.4.1 The Nature of Ethnography

In terms of its research strategies, method, data collection, and data analysis, ethnography generally refers to social research that has most of the following five features described by Hammersley (1998):

- People's behaviour is studied in everyday contexts, (natural everyday group sharing activities) rather than under experimental conditions created by the researcher.
- Data are gathered from a *range* of sources, (refer to Section 2.5.5 below) but participation/observation and/or relatively informal conversations are usually the main sources of data collection.
- The approach to data collection is 'unstructured' in the sense that it does not adhere to a detailed plan set up at the beginning; nor are the categories used for interpreting what people say and do pre-given or fixed. This does not mean that the research is unsystematic; simply that initially the data are collected in as raw a form, and as wide a front, as feasible.
- The focus is usually a single setting or group, of relatively small scale.
- The analysis of the data involves interpretation of the meanings and functions of human actions and mainly takes the form of verbal descriptions and explanations; quantification and statistical analysis plays a subordinate role (as explained in Section 2.3).

Taylor (2002) outlines the following three aspects in response to his question, "*What, then, characterises ethnography*?" (p. 1).

- Researchers set out to study people and aspects of their lives and social worlds, and to produce a research text.
- The research text aims to be comprehensive, nuanced and non-reductive incorporating change and process without resorting to simplistic aetiological models.
- The researchers consciously locate their work within the cross-currents of ongoing critiques and debates about ethnography and qualitative research.

In line with the above two author's features and characteristics of ethnography, Wolcott (1988) succinctly describes ethnography as "*…a picture of* the way of life *of some identifiable group of people*" (p. 188).

Real knowledge of another person requires openness, trust, participation, and empathy. Neuman (2000) emphasizes the aspects of openness, trust, participation, and empathy by stating that *ethnography*, also called *field research* or *participant-observation research*, is "*… a qualitative style in which a researcher directly observes and participates in small-scale social settings in the present time and in the researcher's culture*" (pp. 344-345). There are no abstract deductive hypotheses formulated "*…instead, there is direct, face-to-face social interaction with 'real people' in a natural setting*" (p. 345).

At this stage of the discussion the influence of *postmodernism* on psychological research needs to be mentioned. Briefly, postmodernism refers to the concept of relativism, meaning that if a form of behaviour seems reasonable then allow it, because the behaviour is relative to, and practical within the context in which it takes place. According to Thomas (1993) "*Postmodernists tend to be 'armchair radicals' in that their critiques focus on changing ways of thinking rather than calling for action based on these changes*" (p. 23). Postmodernists do thus not perceive nor approach problem solving in the same structured and responsible way, for instance that grounded theory researchers and action researchers approach problems, as explained in Sections 2.3.4 and 2.3.5 above.

2.4.2 Ethnography is an Inquiry Process

Although ethnography allows for the most flexible of research techniques and procedures, it does not mean that one simply employs many, or even all, of the many research techniques available to ethnographers. At the same time observations and information are not limited by one stringent research design.

Wolcott (1988) believes that "*Ethnography…is not a reporting process guided by a specific set of techniques. It is an* inquiry process *carried out by human beings and guided by a point of view that derives from experience in the research setting and from the knowledge of prior anthropological research...Ethnographic significance is derived socially, not statistically,*

from discerning how ordinary people in particular settings make sense of the experience of their everyday lives" (p. 191).

Deriving ethnographic significance socially, requires an accurate, creative, unobtrusive, flexible, and comprehensive means of data collection, of how ordinary people in their natural environment (a culture-sharing group) make sense out of their experiences of their daily activities.

2.4.3 Applied Ethnography

Using the following key ethnographic concepts (Creswell, 1998), I will briefly summarise the following five examples to illustrate how ethnography has been employed in various settings.

Unit of Analysis refers to the case or unit that the researcher observes and analyses in a study. In ethnography the unit of analysis is the behaviour of the intact **culture-sharing group** which the researcher attempts to understand.
Gatekeeper refers to the person who gives the researcher permission to enter a group or cultural site.
Key informants are those well informed and accessible individuals, with whom the researcher begins the data collection, because they can lead the researcher to other sources of information.
Cultural portrait refers to the holistic view of the culture-sharing group, portraying the final product of the cultural scene in all its complexity.

2.4.3.1 Goffman

Working within an ethnographic paradigm while describing closed worlds, such as prisons, army training camps, monasteries, nursing homes, and with special emphasis on mental hospitals, Goffman (1961) states that: "*Desiring to obtain ethnographic detail regarding selected aspects of patient social life, I did not employ usual kinds of measurements and control*"(p. x).

Unit of analysis (the culture-sharing group): 7000 inmates hospitalized at St. Mary's Hospital, Washington, D.C.
Gatekeeper: The First Assistant Physician and the Superintendent of the hospital.
Key informants: The professional psychiatric staff
Intact groups observed over a long period of time: Psychiatric hospital inmates.
Commitment of the researcher: i) To learn about the social world of the hospital inmates as subjectively experienced by them; ii) abiding with the research agreement as prescribed by the National Institute of Mental Health (NIMH) in Bethesda, Maryland; iii) that the St. Elizabeth hospital would require pre-publication criticism rights, and; iv) that no staff member or inmate would be identified.
Time: One year from 1955 to 1956.
Direct participation observation in everyday situations: Yes, and also that as an observer Goffman (1961) agreed not to interfere with anything he observed happening.
Cultural portrait (final product): i) Mental hospitals exist because there is market for them; ii) the medical-service frame of reference dominates all aspects of the hospital activities, and; iii) mental patients can find themselves in a special bind, because they are caught between the ideal of the supposedly helpful health service offered to them that actually eases life for the rest of the community, more so, than for the patients.

2.4.3.2 Harper

Harper (2003) has conducted a two year ethnographic inquiry, examining the impact of a psychological support programme based on transactional analysis for a group of street children.
Unit of analysis (the culture-sharing group): A group of 30 male street children living in shelters which accommodate street children in Pretoria, South Africa.
Gatekeeper: The house father of the main shelter where the Transactional Analysis programme was carried out.
Key informants: The street children and the trainee peer-counsellors.
Intact groups observed over a long period of time: Participating and interacting with 30 street children and 14 peer-counsellors over a period of two tears.

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Commitment of the researcher: The researcher i) joined as a staff member in the capacity of guidance teacher; ii) established a group of 14 peer-counsellors trained in Transactional Analysis methods, and; iii) submitted a doctoral thesis on her ethnographic inquiry.
Time: 2 years
Direct participation observation in everyday situations: The researcher worked as a guidance teacher for the duration of the study.
Cultural portrait (final product): The intervention of Transactional Analysis allowed the street children through their stories, to express and explore themselves so that they could understand themselves better; were more aware of their beliefs and ways of thinking; were able to gain insight into oppressive relationships; and helped the children to put their past experiences into context.

2.4.3.3 Papaikonomou and Nieuwoudt

Papaikonomou and Nieuwoudt (2004) have demonstrated how ethnographic research has been used to explore parent's stories of coping with their children's cancer.

Unit of analysis (the culture-sharing group): Eight parents whose children were diagnosed with cancer.
The key informants: The eight parents in the regular support group meetings.
Commitment of the researcher with an intact group over a long period of time: 2-3 hour unstructured group interviews over a period of 15 months.
Direct participation observation in everyday situations: Regular meetings were held with an intact support group of 8 parents over a period of 15 months.
Main source of data collection: The stories of the parents.
Outcome of data analysis: Five (5) themes emerged from the stories generated from the interaction between the researcher and the parents.
Cultural portrait (final product): The five themes captured what the parent's crises were about. Also the parent's stories could be related to existing theories. It was essential that the parents perceived their support group as safe and supportive.

2.4.3.4 Taylor

Taylor (2002) illustrates the innovation and variety within recent ethnographic research, comprising of ten studies on four continents, which includes work from a range of disciplines in different national and social contexts, such as medical services, tourists at the Taj Mahal, and the workplace such as a hospital emergency service and an airline cockpit. The following example is taken from Hutchins and Klausen (2002).

Unit of analysis (the culture-sharing group): The cognitive system (information processed from, thoughts, images, expectations, and speech) of a cockpit crew of three, namely the Captain, the First Officer, and the Second Officer, on a simulated flight from Sacramento to Los Angeles.
Key informants: The three cockpit officers in the simulated flight.
Intact groups observed over a long period of time: The three cockpit officers during the second simulated flight for the day.
Commitment of the researchers: The observation, analysis and interpretation of the three crew member's verbalizations and cockpit activities, of a one and a half minute excerpt from the transcript of the simulated flight.
Time: The excerpt of cockpit activity presented for ethnographic analysis was approximately one and a half minutes in duration. The duration of the simulated flight is not mentioned.
Direct participation observation in everyday situations: The researchers were allowed to observe the cockpit activity for the duration of the simulated flight.
Cultural portrait (final product): The analysis identified a set of possible pathways (some anticipated and some not), for communicating and sharing information about the total cockpit system during the Air Traffic Control System clearance-handling events, eight minutes after take off.

2.4.3.5 Ellis and Bochner

Ellis and Bochner (2000) illustrate the art of ethnographic *writing* in such a way that it captures core aspects of narrative style, imparting knowledge, and expressing ideas, feelings, and beliefs in a creative and captivating way.

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Unit of analysis which is the culture-sharing group: The art of ethnographic writing. Neuman (2000) concurs that the themes in people's speeches may be used as units of analysis.

Key informants: The numerous ethnographic writers (authors) referred to in the text.

Intact groups observed over a long period of time: The committed writers authors and researchers publications over the period of approximately 40 years mentioned in the text.

Commitment of the researcher: An analysis of over 200 ethnographic publications.

Time: Since ± 1962 to 2000.

Direct participation observation in everyday situations: The researchers had access to all the publications that they researched.

Cultural portrait (final product): The publication of a truly original and creative demonstration of ethnographic narrative, contributing to one chapter in a Handbook on qualitative research in Denzin and Lincoln (2000).

In the same vein Hammersley (1990), and Van Maanen (1995) draw attention to the different styles or modes the ethnographic writing, expounding on the cautions to be considered and the pitfalls to be avoided.

2.5 METHOD OF THE PRESENT STUDY

2.5.1 Research Setting

The present study took place in the following clinical settings:

- Weskoppies Hospital situated four kilometres from Tshwane (Pretoria) city centre.
- Reference will also be made to Westfort Hospital situated nine kilometres from Tshwane (Pretoria) city centre.
- Reference will also be made to Dr George Mukhari Hospital (formally Garankuwa Hospital) adjoining the University of Limpopo, Medunsa Campus, situated 36 kilometres from central Pretoria.

2.5.2 Access to Settings

- Since 1992 I have occupied a full-time joint appointment with the Medical University of Southern Africa (Medunsa) (now called the University of Limpopo, Medunsa Campus) and with the Department of Health. Employed by the Department of Health, I have worked at the Garankuwa (now Dr George Mukhari), Westfort, and Weskoppies Hospitals.
- Written permission to conduct this study has been obtained from the CEO at Weskoppies Hospital, where I am presently working (See Appendix 1).

2.5.3 Research Settings and Time Frames

During the 16 year period from 1992 to 2008 (pre-apartheid to post-apartheid era), this study relates to work carried out at the aforementioned institutions during the following periods:

- 1992 to 1994 Garankuwa Hospital (2 years).
- 1994 to July 1997 Westfort Hospital (3 years and 7 months).
- 1997 to 2008 Weskoppies Hospital (11 years).
- 1992 to 2008 Assessment of intern-psychologist's clinical cases at Garankuwa (Dr George Mukhari) Hospital (16 years).

2.5.4 Sample –The Culture-Sharing Group

- Mainly male State Patients (Forensic-patients), at Westfort and Weskoppies Hospitals.
- Mainly the Medunsa firm male State Patients, with emphasis on Ward 59, the only ward in the hospital in which staff and patients are housed under one roof at Weskoppies Hospital.
- Non-Forensic male and female patients, at Westfort, Weskoppies, and Garankuwa Hospitals.

2.5.5 Data Collection

In all types of qualitative research, Creswell's (1998) suggests that the main methods employed for data collection, consists of *participation observation*, *documentatio*n, and *interviewing*.

Participation observation refers to the researcher becoming a participant in the culture setting and thus observes by watching and listening to all overt and covert interactions with and between participants.

Documentation refers to all written material in the form of process notes, reports, hospital circulars, and diaries.

Interviewing refers to all formal interviews and informal conversations with all participants.

In the present study data was collected in the following forms and from the following sources.

- **Hospital Diaries.** Information was documented in, and obtained from, the following Hospital Diaries (1994-2008):
  Group psychotherapy sessions (weekly);
  Climate meetings (weekly);
  Multidisciplinary ward rounds (daily);
  Hospital meetings (on an ad hoc. basis);
  Forensic conferences (monthly);
  Multidisciplinary staff meetings (monthly);
  Hand-Over meetings (daily);
  Medical Advisory Committee meetings (monthly).
- **Personal Diaries**
  Personal diaries (1992-2008).
- **Files**
  Patient hospital files;
  Clinical and Applied Psychology patient personal psychology files (CAP/92-CAP/08).
- **Process notes and reports** pertaining to the supervision of intern-clinical psychologists.
- **Informal discussions** shared with patients, staff members, colleagues, and students.

2.5.5.1 Gatekeepers and Informants

Creswell (1998) refers to the *gatekeeper,* as the person who is a member of, or has insider status with the cultural group. In the case of Westfort and Weskoppies Hospitals in which I have been a full time staff member, the main *gatekeepers* were the ward matrons, the professional nurses, the intern-psychologists, and the patients themselves, who led me to other

key informants. The key informants being those well informed individuals who were able to provide leads about additional information. In a very real sense, because I have been part of the interdisciplinary team for many years, all hospital staff members who participated in every daily hand over meeting, staff meeting, and also the staff members and patients who participated in daily ward rounds and weekly group psychotherapy led me to other key aspects of the ongoing inquiry process.

2.5.5.2 Multiple Perspectives

Multiple perspectives refers to the recording of observations, and the understanding of a subject's behaviour in more than one context, and on more than one level. One flexible and comprehensive method that is used in the ethnographic inquiry process, for data collection, by either observing, measuring describing, and/or explaining phenomena, is called the *triangulation* technique, which is a term borrowed from navigation and land surveying that says"*…looking at an object from several different points gives a more accurate view of it*" (Neuman, 2000, p. 521). In a research context, triangulation refers to a method that is used to gather multiple measures of a particular phenomenon in order to gain a more comprehensive account of its occurrence (Creswell, 1998; Hammersley, 1998; Hammersley & Atkinson, 1995; Neuman, 2000). Neuman (2000) explains that triangulation may operate in the following three different contexts:

- Triangulation of *measures* refers to several measures, angles or ways.
- Triangulation of *observers,* which refers to multiple researchers or observers.
- Triangulation *of theory* which refers to multiple theoretical perspectives.

Zuber-Skerritt, (2001) simply describes triangulation as mixing and using multiple measures. Referring to triangulation, Thomas (1993) asserts that one way of minimizing wrong or inaccurate ethnographic accounts, is to utilize different data sources and gathering techniques about all evidence obtained, which enriches the evidence and often allows the researcher to identify potential errors. In the present study a multiple perspective was obtained from my own observations, all members of the MDT, as well as the patients.

The long term commitment on the part of the ethnographic researcher ensures a context of *multiple perspectives*, in which multiple sightings and recordings of the subject's actions, is

achieved. For example, obtaining information and insights from hand over meetings, ward rounds, and the multidisciplinary team members dialogues with each other over a prolonged time, ensures a more comprehensive account of the individuals group sharing behaviour.

2.5.6 Data Storage, Management, and Analysis

All information, except for hospital files, was kept in the offices at the hospital in which the intern-psychologists and I were working. Thus all patient psychology files, reports, and diaries were safeguarded in a central place.

Wolcott (1994) refers to data analysis as transforming the fieldwork into deskwork, which is often a formidable task in ethnography. For the present study however, the data analysis has been a continuous and continuing process for the past fourteen years (since 1994). As indicated above in Section 2.5.5, daily activities have been recorded in a variety of ways and forms. The following three quotations are practical guidelines which I was able to identify with in my ongoing process of data analysis.
(a) Data analysis takes place *"…after recording, gathering, sorting, deciphering analyzing and synthesizing, dissecting and articulating"* (Trinth, in Denzin, 1997, p. 231) of all available information.

(b) The analysis of the data obtained from the culture-sharing group involves the process of *"…reviewing all the data and segmenting them into a small set of common themes, well supported by evidence in the data"* (Creswell, 1998, p. 245).

(c) The analysis of the data obtained in the interactions of the culture-sharing group, involves *"…the interpretation of the meanings and functions of human actions and mainly takes the form of developing a story from which descriptions and explanations are extracted"* (Papaikonomou & Nieuwoudt, 2004, p. 285).

By systematically following the fieldwork procedures of ethnography, information from the sources outlined in Section 2.5.5 above, was sifted and screened, from which categories of information with common themes were extracted. The themes that emerged from studying the behaviours of the culture sharing group, mainly through observations, documents and

interviews were obtained in the following way according to the method outlined by Creswell (1998):

- **Sketching ideas.** Ideas were obtained from topics discussed in group and individual therapies, climate meetings, ward rounds, and from staff meetings in such a way that core issues were identified regarding patients and their family support systems, hospital personnel, and the health care professionals. Files were created and data was organized systematically to capture all information at all times.
- **Taking notes.** Notes were kept in patient's personal psychological files, hospital files, and in diaries which included ward round activities, group therapy activities, and staff meeting activities.
- **Summarize field notes.** I was able to make regular summaries of all notes as a result of weekly and even daily discussions with MDT members, about patient, staff, and hospital issues.
- **Getting feedback on ideas.** During our weekly group therapy meetings, patients would consistently ask for feedback on decisions and goals set in the previous group session. Also the intern-psychologists and I were able to check out with group members if the group's concerns and goals were accurately understood, and realistically dealt with. This process afforded the opportunity to make regular summaries and to clarify ideas on how to address issues which arose.
- **Working with words.** Working in the multicultural context of the hospital the meaning and different interpretations of words had to be clarified to ensure that everyone in the group understood at all times what was being communicated by all group members. A translator from one of the group members was chosen to ensure accurate translation.
- **Display data.** Data was always readily available in files, reports, and diaries. The monthly statistics on all clinical work done by the Medunsa firm was also a means of gaining an overall view of all information about all available data.
- **Identifying and counting frequency of codes.** Identifying codes was easily dealt with. The filing system was uncomplicated and efficient. When computers were introduced into the hospital system in 2001, hospital and regional codes were meant to replace and improve all existing methods of hospital administration, but did not

however affect our daily clinical routine. The monthly statistics that I compiled was also a means of arranging files, reports, and documents in their proper place.

- **Reduce information.** The reduction of information into manageable, practical, and understandable categories was a continuous and continual process, which basically fell into two main categories, namely the patient's needs and the staff member's needs. The social setting of the hospital as described in Chapter 1 above, was taken into account to contextualize and to motivate (justify) why the specific themes were decided upon.
- **Relating categories.** Initially three broad categories were identified, namely the needs, issues and expectations concerning, the patients, the MDT members, and the hospital management. The three categories were seen to be distinctly different from each other to merit separate identities. There appeared to be continual tension between the needs and expectations of the members in each category. Hence it seemed expedient to inquire into aspects of all three categories which appear on Table 2.1 below.
- **Redesign study if necessary.** Within the aims and objective of the present study, ethnography was still seen to been the most suitable method of inquiry into which multicultural influences and dimensions play a part in the psychological treatment and training in the hospital.

Table 2.1. The Main Aspects which centre round the Needs of *Patients*, *MDT Members*, and *Hospital Management* at a Psychiatric Hospital.

Patient's Needs	Mainly Discharge
	• Transfer to an open ward • To live comfortably in the hospital

	• To obtain regular leave of absence (LOA) • To obtain a discharge.
MDT Members' Needs	**Mainly Rehabilitation** • To stabilize the patient's condition as soon as possible with medication and behaviour modification • Assess the risk factors of patient's alleged crime and diagnosis • To identify a suitable custodian • Liaison with the A/G's office • To receive support from hospital management.
Hospital Management's Needs	**Mainly Order, Stability, and Compliance** • To have patient stabilized • To have patient discharged into the community as soon as possible • To ensure that Hospital, Head Office and AG's protocol, procedures, and regulations are carried out.

2.5.7 Writing the Ethnography Text

The writing of ethnography, like any other writing, requires discipline and work (Hammersley & Atkinson, 1995). Together with the disciplined work the ethnographic researcher is encouraged to use a comfortable and expressive style of writing to describe as vividly and realistically as possible what s/he observes in all interactions (Creswell, 1998; Ellis & Bochner, 2000). Creswell, (1998) suggests and encourages that the creativity of the researcher should be reflected in writing about the process using expressive and persuasive language "*…so that the reader experiences 'being there*'" (p. 21).

It is possible and preferable to use linguistically pleasing language to say something profound and important, rather than to use academic jargon. In this way the patient's experiences as understood by the researcher, enables the researcher to relate the *inquiry process* as the patient's story unfolds in ordinary everyday and clear language. Ethnography is indeed an *inquiry process* of understanding how the person's story unfolds in the natural setting, rather than the relating of events in retrospection, without making sense of or

understanding the person's experiences. Ethnography also entails providing detailed descriptions of the communities where the subject's live**,** because their lives *change in response* to various environmental demands, just as the subjects *develop in reaction* to their own maturational changes. For this reason *process*, is emphasized**,** that is, *process to adjustment* (Creswell, 1998). Also, what is observed in the process to adjustment is how human beings learn how to use the elements of the common culture in which they function to serve their individual purposes (Creswell, 1998). For example in Chapters 4 to 8 of the present thesis, reference will be made to several examples of how patients expressed themselves, when they needed to adapt to the changing environmental and situational pressures in their culture-sharing group within the hospital setting.

2.5.8 Critical Ethnography as a Means of Establishing Validity, Credibility, and Relevance

The aspects of trustworthiness, accuracy, and relevance become key issues when imparting information, and when giving an account of people's experiences. Within the context of critical ethnography, Thomas (1993) cautions ethnographic researchers to take note of the following *traps*, and at the same time offers researchers the following *tricks* to avoid the traps while conducting critical ethnographic research. I will sometimes refer to the following traps and tricks in the forthcoming chapters.

Trap 1: Seeing only what serves our purposes
Trick 1: Avoiding imposing meanings on data
The data obtained should "speak" to us, and we should closely attend to all information even if we do not like what we hear and see. "*To do otherwise is not only bad science, it is intellectually dishonest and unethical*" (p. 62).

Trap 2: Using conceptual clichés
Trick 2: Avoid buzzwords
Using jargon can lead to exaggerated claims and distorted conclusions. Ethnography should demonstrate, not assert and should "…*simply describe the terrain and let the readers evaluate the conclusions on the basis of what has been shown*" (p. 63).

Trap 3: Placing passion before science

Trick 3: Avoid axe grinding

The goal of critical ethnography is to describe the data relating to the topic and not to attack a favourite topic. The conclusion should be comprehensive and remain true to the data obtained. "*The adage 'KISMIF'- keep it simple, make it fun – is as true for writing up results as it is for summer camp*" (p. 64).

Trap 4: Making claims beyond demonstrable evidence

Trick 4: Avoid generalizing

Overgeneralizing means that we speak beyond the data. Conclusions should not exceed what the data shows. For example if it is found that "…*men enjoy greater social advantages than women does not mean that 'men create a society so they can oppress women*" (p. 64).

Trap 5: Replacing reason with stridency

Trick 5: Avoid sledgehammers

Good ethnography describes and illustrates rather than asserts. "*Empirical analysis should be thought of as a scalpel, not a cudgel, and the metaphor of incisiveness is more effective than the metaphor of a battering*" (p. 65).

Trap 6: Writing to the already committed

Trick 6: Remember the audience

Ethnographers should not try and convince those that are already convinced of the topic being inquired into. The guiding principle should be one of finding ways to communicate all important information in a language that the audience can understand. "*We must therefore be fluent in three languages: that of the subjects, that of our own science, and that of the audience*" (p. 66).

Trap 7: Forgetting the ethnographic project

Trick 7: Appreciate difference

To appreciate difference means to confront and unshackle common sense beliefs, and to place familiar and unfamiliar concepts and issues, in a new context.

Trap 8: Taking ourselves as given

Trick 8: Discover reflexively who we are

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The researcher is part and parcel of the research process. The ethnographer attains reflexive understanding by engaging in critical and objective self-dialogue. Self questions asked may take the form of "*What are the epistemological foundations of my study*?", "*How would my study be done differently if done with statistical analysis*?", "*What are the ethical implications of the research*?", and "*How did the research change me or my subjects*?" (p. 67).

2.5.9 Reading, Assessing, and Interpreting Ethnography

When it comes to reading, assessing, and interpreting the information gained from all inquiry made from ethnographic research, Hammersley (1990) gives the under-mentioned criteria which may guide the researcher. Although the criteria are applicable to ethnography, they are equally applicable to all types of quantitative research.

Together with Thomas's (1993) "Traps and Tricks" discussed in Section 2.5.8 above, I will sometimes refer to Hammersley's (1990) criteria in the forthcoming chapters.

(a) The degree to which substantive and formal theory are produced and the degree of the development of the theory.

(b) The novelty of the claims made.

(c) The consistency of the claims with empirical observations.

(d) The credibility of the account to readers and/or to those studied

(e) The extent to which the cultural description produced provides a basis for competent performance in the culture studied.

(f) the extent to which the findings are transferable to other settings;

(g) the reflexivity of the account: the degree to which the effects of research strategies on the findings are assessed and/or the amount of information about the research process that is provided to readers.

2.6 CONCLUSION

In this chapter I have discussed the key concepts of ethnography in relation to the general principles belonging to qualitative and quantitative research paradigms. The nature of ethnography was discussed. Ethnography is seen as an inquiry process rather than a reporting process. Examples of the application of ethnography in social and clinical settings were

given. The method of the present study with reference to the hospital setting, the culture-sharing group (sample), the way the data was collected and analyzed was elaborated on. The validity and relevance of ethnography was taken into account and will again be addressed in Chapters 4 through to 10.

In the present study it will become evident that ethnography works best because it occurs in a real live situation where people are themselves in a natural context, without any unnecessary tension and anxiety, and no expectation in which participants will be tempted to artificially put on an image, front, or pose. Our *thoughts, feelings*, and *actions* play a central part in our total functioning. It is therefore necessary to capture as much information generated from these three dimensions as possible when:

- people's behaviour is studied in everyday contexts;
- data are gathered from a *range* of sources; and
- interpretation of the meanings and functions of human actions mainly takes the form of verbal descriptions and explanations;

Referring to the above, Denzin and Lincoln (2005) aptly remarks that "*It is not enough to understand the mechanics of interviewing; it is also important to understand the respondent's world and forces that might stimulate or retard responses. …* [the structured interview] *often elicits rational responses, but it overlooks or inadequately assesses the emotional dimension*" (p. 703).

Before the ethnographic description of the culture-sharing group receiving treatment is discussed I will outline in the next chapter aspects relating to psychological treatment, namely psychotherapy.

CHAPTER THREE

PSYCHOTHERAPY

3.1 INTRODUCTION

As I take stock of my exposure to the past 36 years of the psychotherapy literature, and of how it has been applied in the training and teaching of psychotherapy, I would like to focus on how the major theoretical psychotherapeutic approaches have grounded me in the field, and have shaped my application thereof. In this chapter I will outline my acquaintance of the general tenets and principles of psychotherapy over the past years, with a brief outline of the research and clinical evidence of the effectiveness of psychotherapy. Relevant aspects relating to International, Eurocentric, and African psychotherapy are also discussed. The important features of the ecosystemic psychotherapeutic approach are contextualized. Aspects relating to group psychotherapy are also discussed.

3.2 DEFINITION OF PSYCHOTHERAPY

Wolberg (1977,) gives the following comprehensive working definition of psychotherapy. "*Psychotherapy is the treatment by psychological means, of problems of an emotional nature in which a trained person deliberately establishes a professional relationship with the patient with the object of (1) removing, modifying, or retarding existing symptoms, (2) mediating disturbed patterns of behaviour, and (3) promoting positive personality growth and development.*" (p. 3).

Twenty seven years later The Multicultural Psychotherapy Association (2004) defines psychotherapy as follows**.** "*Psychotherapy is the interactive process in which a person recognizes, confronts, and works with conflicting situations within his or her* ***personality****,* ***relationships*** *or* ***life circumstances*** [words in bold added]. *The goal is to relieve suffering, empower and raise a person's awareness about his or her life, and resolve the situation.*"

Hock (2005) simply states that: "*Psychotherapy simply means therapy for psychological problems. Therapy involves a close and caring relationship between a therapist and a client*" (p. 258).

The above three definitions in unison with the numerous other definitions of psychotherapy cited in the literature, illustrate, emphasise, and imply the following common and central elements in psychotherapy:

- A therapeutic alliance between therapist and client working towards a mutually decided upon goal.
- A process during which conflicts are addressed on the cognitive, emotional, and behavioural levels.
- Emphasis is placed on an individual's *personality*, which refers to her/his intrapsychic aspects, *relationship* which refers to the interpersonal aspects and *life circumstances*, which refers to the environmental, systemic, and cultural aspects of the person's functioning.
- Psychotherapy is partly art and partly science. The blend of objectivity (science) (Bergin & Strupp, 1972) and subjectivity (art) (Bugental, 1987), is essential in allowing the therapist to use his total being. Keeney, (1983) succinctly captures this aspect: "*Thus, art, whether in therapy or a concert hall requires both left and right brain mentation. This reminds us first of all, that art always includes technique. …At the same time, an emphasis on technique without regard for the more encompassing aesthetic patterns leads to a mechanical sterile performance*" (p. 304). Psychotherapy can thus be applied in a biomedical *and* reductionistic way, or can follow a more comprehensive model such as the biopsychosocial, or eclectic, integrative, or systemic approaches.

3.3 MECHANISMS AND INGREDIENTS OF PSYCHOTHERAPY

Psychotherapy essentially deals with the *cognitive, emotional,* and *behavioral* aspects of a person's functioning. Keeping within this framework, Corsini and Wedding (1995, 2005, 2008) refer to the literature search in which Corsini and Rosenberg (1955) identified nine key factors or *mechanisms*, which constitute the basis for a person's change while undergoing

psychotherapy. The nine factors (*mechanisms)* fall within the following three broader categories.

3.3.1 Cognitive Factors

Universalism means that patients improve when they realise that suffering is universal and that many other people have similar problems. **Insight** refers to the growth which occurs when clients gradually obtain a better understanding of themselves and when they obtain a more objective and realistic perspective of their motives and behaviour. **Modelling** alludes to the occurrence of people benefiting when they observe and imitate other people, including the therapist.

3.3.2 Affective Factors

Acceptance means that by receiving unconditional positive regard, especially from the therapist, enables and encourages the client to be her/himself. **Altruism** develops when the client is the recipient of acceptance, love and care from the therapist, or other group members, then the client may also impart these qualities to others, thereby feeling s/he is helping others**.** **Transference** refers to the emotional bond that develops between the client and the therapist, or between the client and group therapy members.

3.3.3 Behavioural Factors

Reality testing refers to the change that becomes possible when the client is able to experiment with new behaviours in the non-threatening therapy situation, during which support and feedback is received from the therapist and other group members. **Ventilation** refers to the situations during which the client is able to "blow off steam", through shouting, crying or expressing anger in the context in which s/he still feels accepted. In **interaction** with each other, patients improve when they openly admit to themselves, to the therapist, and to the group members that there is something wrong with themselves.

In summing up the above factors Corsini and Wedding (1995) encapsulate the essence of psychotherapy by stating that, "*Close examination of this model reveals that the cognitive factors imply* "Know yourself,*" the affective factors tell us* "Love your neighbour,*" and the behavioural factors essentially suggest* "Do good works." *Perhaps there is nothing new under the sun, for this is what philosophers have told us for millennia: know thyself, love thy neighbor, and do good works*" (p. 10).

The cognitive (thoughts), affective (feelings), and behavioural (actions) aspects of human functioning are the dimensions in which all psychotherapeutic work is done. For example what is commonly known as a mental status examination (DSM-IV-TR, 2002), or as a psychological assessment and treatment plan, Brooks-Harris and Gavetti (2008) have compiled an integrative treatment plan based on a *multidimensional survey* in which *thoughts*, *actions,* and *feelings* are the key dimensions of the *survey*. The other four dimensions on Brooks-Harris and Gavetti's (2008) *multidimensional survey* are the influences that *biology*, *interpersonal patterns*, *social systems*, and *cultural contexts*, play in a person's functioning.

3.4 RESEARCH AND CLINICAL EVIDENCE

When scrutinizing the literature it thus becomes apparent that the differing theoretical models have the common goal of improving the quality of one's life. Improving the quality of one's life may mean different things to different people. Psychotherapy is beneficial, effective, and necessary with people in everyday walks of life, not only for the mentally ill. Psychotherapy is commonly referred to as a helping and healing profession in that it assists in *promoting positive personality growth and development* (Wolberg, 1977), and *relieves suffering* (Corsini & Wedding, 1995, 2005, 2008; Multicultural Psychotherapy Associaties, 2004). The *art* of helping and healing cannot be quantified; the *scientific* variables related to helping and healing however can be quantified. The effectiveness of psychotherapy as supported by clinical and research evidence is well documented. The central ingredients of why psychotherapy works effectively has been researched and documented by a multitude of authorities, such as Bergin and Garfield (1994), Bergin and Strupp (1972), Bugental (1987), Egan (1975, 2002), Garfield (1992, 1995), Lambert (2004), Rogers (1951, 1967), and Truax and Carkhuff (1977). The central ingredients of psychotherapy are contained in *establishing a relationship of trust* with the client. This means the therapist's ability to provide a non-

threatening, trusting, safe, and secure atmosphere by her/his warm and genuine acceptance of the client Virtually all theories of psychotherapy emphasise that for the therapist to be helpful s/he must be "…*accurately empathic, be 'with' the client, be understanding, or grasp the patient's meaning*" (Truax & Carkhuff, 1977, p. 25). As a result of the well documented research evidence, it is generally agreed upon that the *three* key *therapeutic ingredients* (Rogers, 1951, 1967; Truax & Carkhuff, 1977) related to psychotherapy, are *accurate empathic understanding*, *unconditional positive regard* (non-possessive warmth), and *congruence* (authenticity, genuineness). **Accurate empathic understanding** refers to the therapist's ability to sense the inner world of the client's subjective experience. **Unconditional positive regard** refers to accepting clients as worthy persons. **Congruence** refers to the therapist's genuineness.

Freedheim (1992, 2003) and his co-workers have critically scrutinized the theoretical, research, clinical (practical), and training (educational) aspects of psychotherapy for the one hundred year period, between 1892 to 1992. Within the context of psychotherapy intertwined with the history of USA, Cushman (1992) states that "*Psychotherapy is one of the most complex, colourful, and significant artefacts of our modern American terrain, reflecting and shaping the central themes of the past 100 years*" (p. 21). The historical contexts of international psychotherapy have been embedded in European, Victorian and American antecedents. Cushman, (1992) is also of the opinion that in its development, psychotherapy has also progressed through modern confusion and what he calls 'postmodern emptiness'.

3.5 INTERNATIONAL PSYCHOTHERAPY

Mkize (2003) a South African psychiatrist, states that international psychiatry has its roots in the Anglo-European ideas and methods on mental health and illnesses, belonging to the 19th century. During the 19th and 20th centuries a medical and organic approach to mental illness evolved. Currently there are two international diagnostic and classification systems in use, commonly known as the DSM (Diagnostic and Statistical Manual of Mental Disorders) and the ICD (International Classification of Diseases), thus creating an international system of diagnosis and classification in a common scientific language which may be applied in an effective way across all national boundaries (DSM-IV-TR, 2002). The DSM has been updated

to the DSM-IV-TR (Text Revision) since 1952, and published by the American Psychiatric Association (APA, 2002; Freedman, et al., 1976; Kaplan & Sadock, 1998). The ICD-6 was published in 1948 by the World Health Organization in Geneva Switzerland, (Freedman, et al., 1976) and is currently updated to the ICD-10 (APA, 2002).

Schlebusch, (1990) cautions that the DSM and ICD classification systems are not always applicable in culture bound or culture specific syndromes such as those found in South Africa. In the application of the DSM-IV in South Africa, Pretorius (2001) reassures his readers by stating that "*A cultural formulation should systematically take into account the patient's cultural background, the role that culture plays in both the expression and evaluation of symptoms, and the relationship between the individual and the clinician*" (p. 11). Drennan (2001, p. 404) clarifies this aspect by asserting that the latest DSM does in fact provide the following series of headings that can be used to organize cultural information that is relevant to the assessment and treatment of patients:

- Cultural identity of the individual.
- Cultural explanations of the individual's illness.
- Cultural factors related to psychosocial environment and levels of functioning.
- Cultural elements of the relationship between the individual and the clinician.
- Overall cultural assessment for diagnosis and care.

The whole question of culture and diagnosis is an ongoing controversial issue, as Slife (2004) asserts: "*Diagnosis also depends on the simultaneous culture or context of the person being diagnosed. Even the notion that one should be diagnosed could be a product of culture in this sense*" (p. 67).

Keeping within an international context Bynum (1999), a North American clinical psychologist, gives a controversial yet enlightening account in his book entitled *The African Unconscious*. By linking the past history of humankind with the predicted future of psychology, Bynum (1999) boldly asserts that all humankind are one in our origins and one in our "*…primordial collective unconscious shared by all human beings regardless of race, sex, or historical time*" (p. 155). The author motivates his contention by stating that Europe, Asia and the Americas are inextricably connected with the destiny of Africa from which humankind's origins began.

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3.6 EUROCENTRIC PSYCHOTHERAPY

It is generally accepted that Sigmund Freud who started out as a neurologist in Austria, is regarded as the pioneer of psychotherapy. Freud's (1979) psychoanalytic theory, or the fundamental concepts belonging to his theory, have been debated upon, criticised, departed from, and reformulated into all the present existing theories of psychotherapy. While Freud (1979) emphasised a person's personal unconscious, and instinctual sexuality and aggression, Jung (1963) a Swiss psychiatrist, emphasised a person's collective unconscious (body, mind, and spirit), and Alfred Adler an Austrian psychiatrist, emphasised the interpersonal and social influences which play a key role in a person's development and behaviour (Corey, 2005; Corsini & Wedding, 1995, 2005, 2008).

3.7 AFRICAN PSYCHOTHERAPY

Referring to the traditional way in which *psychoanalysis* is used Mkize (2003) makes the following appeal:

"*All traditional types of psychotherapy must obviously reflect local beliefs regarding human nature, and in many cultures this means that the close links between individuals their ancestors and the spirit world play a prominent role in treatment. Healing is based on the establishment and maintenance of satisfactory relationships between these different elements – the present, the past, and the spirit world*" (p. 4).

Mkize (2003) goes on to say that the patient, like other community members, does not consider the illness as something to be cured or controlled, but to be seen as a temporary condition to be acknowledged, and its meaning and significance to be understood. The question to be shared with the patient is not *how*, but *why* things happen; in other words to make sense out of what is happening in the patient's life. In essence Drennan (2001) agrees with Mkize (2003) by stating that: "*It would be inappropriate for clinicians trained in a Western model to make diagnoses of traditional African illnesses. Not only are they not*

qualified to do so, there is also no evidence that the traditional categories offer 'better' or superior diagnoses in non-Western patients" (p. 404).

For example using structured clinical interviews in a sizeable sample of Xhosa patients diagnosed as schizophrenic with a homogenous ethnic background, Niehaus (2005) found that schizophrenia is a heterogeneous disorder which has been shown to have *both* environmental and genetic risk factors "*….family history (genetic loading) of psychosis appears to be one of the strongest risk factors for the development of schizophrenia (p. 10)*, and that "*Factor analysis showed that the core symptoms of schizophrenia remained the same across ethnic boundaries. This again reiterates the universality of schizophrenia core symptoms. Results obtained in this Xhosa population can therefore presumably be generalized to other ethnic groups*" (p. 13).

The cultural and contextual information as well as the patient's perspective may contribute significantly to the management of the illness. Regarding the diagnosis of depression in black South Africans, Bodemer (1984) recognizes that "*A good knowledge of the culture, customs, language, as well as of the literature, will help with the diagnosis of depression in Black South Africans*" (p. vii). Malcolm and Berard (2001) emphasise the importance of psychosocial interventions in the context of South African psychiatry.

Keeping Mkize's (2003) suggestion in mind, it should be noted that Kelly's (1955) personal construct theory is an example of how this proposed personalized approach to clinical diagnosis and treatment, has already been implemented and researched for many decades in the domain of formal psychotherapy, especially with patients who manifest with schizophrenic thought disorder (Bannister, Adams-Webber, Penn, & Radley, 1975; Bannister & Fransella, 1971; Brown, 1981; Kelly, 1969; Olwagen, 1981). Bynum (1999) has already expanded the concept 'Afrocentric' to include all psychological concepts already known, and will be known in the future, by intimating that all healing processes are already embedded in the *African Unconscious*. According to Bynum (1999) it is up to present researchers and clinicians to focus their energies and expertise in the direction of the unfolding of the *African Unconscious*, meaning that all ideas and instincts originated in, and evolved from, the still developing Africa from which all humankind's origins began.

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3.8 ECOSYSTEMIC PSYCHOTHERAPY

Ecosystemic psychotherapy which is based on General Systems Theory (GST) postulates that all systems and sub-systems of a person's functioning are linked through recursive patterns of interaction which render them interdependent (Vorster, 2003). In other words the interplay of all aspects of a person's functioning, interior as well as exterior are taken into account. Interior experiences are the individual's subjective experiences which may be described as any pleasant or unpleasant thoughts, and/or feelings, and/or sensations (experienced by one of the five senses). Exterior aspects of the person's functioning takes into account all environmental influences such as home, family, work, cultural, political, social, and financial, which play a part in the individual's life.

3.8.1 Historical Background

The ecosystemic approach to psychotherapy, based on General Systems Theory (Bateson, 1976; Haley, 1963; Keeney, 1979; Keeney & Sprenkle, 1982; Von Bertalanffy, 1966; Watzlawick, et al., 1968), started in the 1950s, and is also referred to as *systems approach*, c*ybernetics*, *family therapy*, and currently includes *narrative therapy* (Phipps, 2004). During its inception, the ecosystemic approach, offered a new perspective of how people related to or interacted with each other. The emphasis was on *inter*-psychic rather than *intra*-psychic processes. Instead of treating people in isolation as Freud (1979) did, people were seen as a unit, and treated together as a system, a couple, family, or community. Ecosystemic psychotherapy thus deals with the interrelatedness and interdependence of all systems in which an individual functions. Illness or psychopathology is the result of a loss of balance involving the interplay of all aspects of a person's functioning, interior as well as exterior.

In South Africa the ecosystemic approach to psychotherapy has been adapted and refined by clinicians such as Fourie (1998), Swart and Wiehahn (1979) and Vorster (2003). An essential part of assessing the essence of the process taking place between the client and the psychotherapist is known as the *interactional analysis*. Braz's (1979) recommendations laid the foundation which paved the way on which a more structured, objective and scientific assessment could be carried out on the research related to the future exploration of

interactional analysis. Based on the principles of General Systems Theory, Vorster (2003) has devised a practical diagnostic procedure, namely the Interactional Pattern Analysis (IPA), which focuses on the interaction between client and therapist that highlights the disturbances in the communication pattern between client and therapist, enabling the therapist to formulate an effective treatment plan in line with the diagnosis made. Further research done on Interactional Pattern Analysis enabled Vorster (2003) and his colleagues (Barlow, 2003; Peters, 2003; Venter, 2004), to refine the systematic and detailed evaluation of how a client relates to a therapist. The IPA consists of a framework of the following sixteen standard questions which the therapist uses to assess the interactional pattern which unfolds during the person-centered interaction. The way in which the IPA questions may be used in order to arrive at a descriptive diagnosis, and tentative hypothesis, will be illustrated in Chapter 4, Section 4.8.

3.8.2 Interactional Pattern Analysis (IPA)

During the person-centered interview the therapist uses the following sixteen questions to evaluate the pattern of communication between him/herself and the client in order to arrive at a hypothesis about the client. An example of how the under mentioned questions are used is illustrated in Chapter 4 Section 4.8.

- Give the context in which the observation takes place.
- Where applicable, sketch the presenting problem.
- Describe the definition of the relationship between you the therapist and the client?
- At the end of the session do you the therapist feel closer or more distant towards the client?
- At the end of the session do you the therapist feel confused or clear about the picture that you have of your client?
- At the end of the session do you feel at ease or defensive towards your client?
- At the end of the session do you feel acknowledged or rejected by your client?
- At the end of the session do you experience your client as congruent or incongruent?
- In the client's system does s/he give empathy and does s/he receive empathy?
- In the client's system does s/he give and receive confirmation and recognition?
- Is the client in control of his/her environment or is the environment in control of the client?

- Does the client effectively express her/his needs?
- What is the client's degree of interpersonal rigidity?
- Does the client exhibit effective problem solving skills?
- Does the client exhibit interpersonal insight including the circular nature of behaviour?
- Does the client exhibit the ability to meta-communicate?

3.8.3 Present Status

Within the South African context, Phipps (2004) asserts that the application of General Systems Theory "*…remains one of the most comprehensive, revealing, and exiting approaches to the practice of psychotherapy*" (p. 431). Internationally, systems theory has enjoyed such widespread success and has undergone such rapid development during the last three to four decades that the *theoretical developments* have been unable to keep abreast of the latest *therapeutic developments* within General Systems Theory (Phipps, 2004).

Before I give a critique on the overall effectiveness of General Systems Theory (GST), I want to briefly align GST with the following psychotherapeutic models:

- The Biopsychosocial Model.
- Eclectic and Integrative Psychotherapy Models.
- The Transtheoretical Model.

3.8.3.1 The Ecosystemic Model subsumes the Biopsychosocial Model

According to Schlebusch (1990) the biopsychosocial approach is rooted in systems theory. The ecosystemic model incorporates and subsumes the *biopsychosocial* model (Schlebusch, 1990; Thomson & Van Loon, 2002) because the person's total functioning in all intrapersonal, interactional, intercultural, and environmental contexts is taken into account.
In a study carried out by Papaikonomou (1989), which encourages medical doctors to adopt a more holistic perspective, the study focuses on the total person in her/his environment, in which the balance and harmony of body and mind in the person's life and environment is sought. Recommending that a biopsychosocial model is adopted Papaikonomou (1989)

suggests that "…*arriving at rational treatments and patterns of health care, a medical model must also take into account the patient, the social context in which he lives, and the complementary system devised by society to deal with the disruptive effects of illness, that is, the role of the physician and the health care system*" (p. 104).

From a cultural psychiatric perspective, Drennan (2001) acknowledges that it is important to distinguish between disease and illness. *Disease* refers to the presence of biological or psychophysiological pathology, while *illness* refers the individual's subjective experience of, and response to the presence of symptoms. A thorough understanding of cultural factors and the incorporation of these factors into treatment plans is vital at all levels of clinical practice. Cultural psychiatry thus contributes towards accommodating the psychological, physical, familial and cultural aspects of health.

At the beginning of the twentieth century, Jung (1963) had already realized the importance of looking beyond observable symptoms, when he stated that: "*In therapy the problem is always the whole person, never the symptom alone. We must ask questions that challenge the whole personality*" (p. 138).

3.8.3.2 Ecosystemic Psychotherapy and Eclectic and Integrative Psychotherapy

Ecosystemic therapy has developed an *epistemology* (the study of how we know, or a comprehensive way of thinking), which entails the *conceptual basis* on which all aspects of psychotherapy, is based, as described in Sections 3.2 and 3.3 above, and should be distinguished from *eclectic therapy* which traditionally has focused on *techniques* borrowed from different therapeutic approaches. Garfield (1995) has however combined the concept *eclectic* with the construct *integrative*, to emphasise and illustrate the therapeutic factors and procedures common to most forms of psychotherapy. Bergin and Garfield (1994) clearly support the viewpoint of *integrative psychotherapy* that has been slowly dominating the field of psychotherapy since the mid 1980's. In their preference for supporting the term *integration* over *eclecticism* Bergin and Garfield (1994) state that integration implies "…*a systematic use of concepts and techniques from different approaches as opposed to a hodgepodge of clinical techniques that might otherwise be applied in a simplistic and impromptu pragmatism*" (p. 821). The concept of psychotherapy integration (Norcross &

Goldfried, 1992) approximates and closely resembles the transtheoretical approach as formulated by Prochaska and Norcross (1999).

3.8.3.3 The Ecosystemic Model seen in Context with the Transtheoretical Model

Unlike the ecosystemic model which focuses on the interconnecting systems in which the individual functions, the transtheoretical model focus on the "best" theoretical principles belonging to the various systems of psychotherapy which may be used for behaviour change generally. Prochaska and Norcross (1999) explain: "*The transtheoretical model begins with a comparative analysis of the major systems of psychotherapy within the integrative spirit of seeking the best that each has to offer*" (p. 488). Thus psychotherapy and behaviour change is drawn from the entire spectrum of major psychotherapy theories. In a similar vein, in their multitheoretical and multicultural workbook, Brooks-Harris and Gavetti (2005a, 2005b, 2008) have introduced a multidimensional survey in which suitable treatment strategies (*cognitive, behavioural, experiental-humanistic, biopsychosocial, psychodynamic-interpersonal, systemic-constructivist, and multicultural*), may be applied, in a multicultural setting, depending on the information gained from the multidimensional survey. The way in which Brooks-Harris and Gavetti's (2008) model may be used will be illustrated in relevant sections of this thesis.

Lazarus (1997) has an opposite viewpoint. Within the context of his multimodal therapy model and as a response to Donald Meichenbaum's feedback and discussion that the field of psychotherapy needs to move beyond an atheoretical technical eclecticism, Lazarus (1997) responds by saying: "*Allow me to correct a false impression. My technically eclectic, multimodal approach is not atheoretical. It rests on a broad-based social and cognitive learning theory to which elements from a general systems theory perspective are also included.* ***I am opposed to theoretical integration*** [bold words added] *and draw only on theories that can be verified or disproved. The foregoing theories seem to blend harmoniously into a broad-based range of factors that seem to account quite adequately for most vagaries* (whimsical or extravagant notion; caprice; freak) *of human conduct and personality*" (p. 93).

From a practical and clinical viewpoint it is my opinion that the four abovementioned models, namely, ecosystemic, biopsychosocial, eclectic-integrative, and transtheoretical models as

explained by the authorities, attempt to understand all possible relevant aspects which play a role in the person's malfunctioning, and attempt to treat the dysfunction accordingly. Each of the four paradigms however, emphasises and punctuates different aspects of the individual's total functioning. Sometimes, understanding and treating the *cause and affect* aspects (*linear*), of a patient's condition is effective in itself. At other times, *the patterns of communication* in the systems in which the patient functions *(non-linear)*, needs to be understood and treated. More than often, a combination of both linear and non-linear approaches needs to be fully understood and implemented in order to resolve the patient's problem. Referring to the many competing therapeutic models and the role that research plays, in his paper presentation, Fourie (2006) boldly asserts that research *guides* psychotherapy and that research should *not dictate*. For example, currently, cognitive behavioural therapy is popular and may be over used by upcoming and ambitious psychologists, but *the type of therapy that helps the patient* is the best kind of therapy for that patient. If the patient benefits then that is the best kind of therapy for the patient no matter what research shows. It is thus evident that psychotherapists should become familiar with all the mainstream psychotherapeutic approaches, which will be discussed in chapter 4. The words of Laing (1974) capture the essence of the abovementioned diccourse: "*Psychotherapy must remain an obstinate attempt of two people to recover the wholeness of being through the relationship between them*" (p. 45).

3.8.3.4 Overall Effectiveness of, and, Criticism of Systemic Therapies

Prochaska and Norcross (1999, 2003, 2007) give a detailed critique of systemic therapies. The authors assert that the epistemology on which systemic therapies are based is incompatible with the assumptions of the scientific method. Furthermore outcome studies using the guidelines of systemic epistemology have not been published. For example from a psychodynamic perspective, systems therapies are regarded to be simplistic because the history of the family, the patient's development, and their internal dynamics are simply ignored. From a humanistic perspective, individuals and families are seen to be been tricked into changing their behaviour, and have not been treated with respect. This refers to the temptation of *duplicity* on the therapist's part, meaning that even with her/his best intentions of assisting the client, the therapist may become prone to deliberate deceptiveness in her/his behaviour or speech, in order to bring about the desired change that the therapist deems necessary. Non cooperation in therapy is seen to be the patient's resistance, and not the

therapist's techniques, when in fact the therapist's technique may actually encourage the patient to resist the therapist's strategies. Prochaska and Norcross' (1999, 2003, 2007) criticism levelled against systems therapy relies mainly on the lack of outcome studies and published research. As psychotherapy has developed over the past century it has become evident that a new code of psychological treatment, rooted in all strategies, ethics, and techniques of healing, is required to support and sustain treatment and rehabilitation programmes in mental health. However, the clinical usefulness of how the ecosystemic model has been applied as a meta-theoretical approach in a society undergoing rapid transformation will become evident in the following chapters.

In her research within the Medunsa context Bosman's (2005) suggests that ecosystemic language needs to be translated into ordinary everyday language when used in ward rounds and in contexts in which systemic terminology is unfamiliar. This recommendation is in line with how ecosystemic thinking encourages attentiveness and sensitivity in the context in which the therapist communicates, be it in a MDT ward round, seminar, lecture, therapeutic, or social setting. For example commonly used ecosystemic jargon such as *escalate*, *manoeuvre,* and *punctuate* can be replaced with ordinary everyday words. The term *escalate* can be changed to words, and phrases such as, aggravate, exacerbate, prolong, intensify, provoke, reinforce in an unfavourable way causing a negative outcome in the interaction. The term *manoeuvre* may be translated to, tend to; to be inclined to; to approach; to ask for; to seek; to aim, to move, and to steer towards. Thus the behaviour described as *manoeuvring* can mean, wanting to be admired; desiring to gain recognition; seeking pathological attention, or just seeking ordinary understanding. These observable behaviours reveal the clients intention, which may or may not be interpreted in a favourable light by the therapist. These behaviours have the implication and connotation that the person is in control and knows what s/he is doing, on a conscious level. Finally the term *punctuate* may be explained to have the connotation of, to emphasise; to stress; to focus; to highlight; to be seen from a particular vantage point. One way in which systemic thinking can be made more acceptable, is Hoffman's (1985) suggestion, that during team discussions, it is important to start with linear points of view, and then to move to more circular ones later in the discussion.

In summary, the ecosystemic model in the present study used as a meta-theory, that is, as a fundamental and umbrella theory, acknowledges and incorporates psychodynamic,

behavioural, cognitive, humanistic, and neuropsychological perspectives. This approach which has been used by the Medunsa Firm psychologists and intern-psychologists, at Garankuwa (Dr George Mukhari) Hospital (1993-2008), Westfort Hospital (1993-1997) and Weskoppies Hospital (1997-2008), has been effective in addressing the many interrelated sub-systems in which patients have been functioning in a society in rapid transition. In its practical application at Westfort and Weskoppies Hospitals the ecosystemic model as used by the Medunsa Firm, has been applied as an integrative model described by Bergin and Garfield (1994) without claiming to be so.

3.9 GROUP PSYCHOTHERAPY

While perusing the literature for the origins of group therapy, I came across various explanations. The following three accounts create contexts which emphasise different points of view, while however agreeing that the term *group psychotherapy* has one origin:

- In the early 1900's Dr. J. H. Pratt, a medical practitioner, combined classroom instruction with the mutual support that his patients gave each other. The inspiration for using this procedure came partly from his reading of the French psychiatrist by the name of Dejerine, and partly from his own conviction that a group context could be supportive to medically ill individuals in their struggles to regain or maintain their health. (Rosenbaum, Lakin, & Roback, 1992). Rosenbaum et, al. (1992) point out that: "*What we usually think of as psychological understanding or self insight played virtually no role in his groups. Nevertheless, the elements of mutual comradeship and support as well as explicit or implicit criticism are still major aspects of all group therapies, even self-help organizations and Quasi-therapy experimental groups*" (p. 699).

- It is generally agreed that in 1932 Jacob Levy Moreno coined the term "group psychotherapy" (Corsini & Wedding, 2005; Marineau, 1989; Mullan & Rosenbaum, 1962; Rosenbaum, et al., 1992; Shafer & Galinsky, 1974), which was also referred to as the *Theatre of Spontaneity* and as *Psychodrama.* Marineau, (1989) explains as follows: "*The year 1932, when Moreno presented his results at Sing Sing* (prison)(my inclusion) *to the American Psychiatric Association, is generally given as the date*

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when the term 'group psychotherapy' was used for the first time in the history of the social sciences" (p. 112). The difference between psychodrama and group psychotherapy is that *psychodrama* refers to the therapeutic method developed by Moreno consisting of exploring life situations and conflicts by *enacting* them rather than talking about these conflicts and situations, according to a systematic and highly creative manner which Moreno developed (Blatner, 2005; Marineau, 1989).

- Shaffer and Galinsky (1974) state that the development of modern group therapy probably began in 1889 with the opening of Hull House in Chicago, USA by Jane Adams. The guiding ideal of Hull House was social reform, with the overall emphasis for self help groups to fight for improved housing, better working conditions, and increased recreational and educational opportunities. Shafer and Galinksy (1974) distinguish between two broad categories of group therapy, namely *psychotherapy,* and *human relations training*. Depending on the purpose and goals of the group will determine whether the group will become a psychotherapy group or a human relations training group.

Corsini and Rosenberg (1955), referred to in Section 3.3 above, arranged, classified, and synthesized some 200 items from 300 pre-1955 group therapy articles into nine major categories which were called *mechanisms of change* or *curative factors* in psychotherapy. Since 1970, Yalom (1975) singled out eleven core aspects, or *curative factors* experienced in group therapy processes. Yalom's (1975, 1995, 2005) classic text has been an imposing force in the literature for several decades, and has become an accepted standard text for mental health professionals involved in group psychotherapy.

3.9.1 Irvin Yalom's Contribution to Group Therapy

Yalom (1975, 1995, 2005) outlines and discusses in detail, eleven curative factors that play an essential part in group psychotherapy. The eleven *curative factors* (Yalom, 1975) which he later calls *therapeutic factors* (Yalom, 1995) facilitate therapeutic change through the process of an intricate interplay of the patient's human experiences. Briefly then a summary of the role of the eleven therapeutic factors.

Instillation of hope: Faith in the treatment process, in self, and in the therapist, facilitates change.

Universality: The realization that we are not unique in our struggles and suffering; sometimes we are all in same boat despite our heightened sense of aloneness.

Imparting of information: Advice, guidance, suggestions, and instructions on the part of the therapist and/or group members can assist in facilitating the group process.

Altruism: Patients receive through giving of themselves and develop the sense that they have something of value to offer and give that will be beneficial to other group members.

The corrective recapitulation of the primary family group: Having the opportunity to correctly relive the unsatisfactory experiences of the family group, and working through unfinished business from long ago.

Developing of socializing techniques: The development of basic social skills is a curative factor. The group is often the first opportunity to experience accurate interpersonal feedback.

Imitative behaviour: Patients may model themselves on the behaviours and communication patterns of the therapist and group members, such as self disclosure and support.

Interpersonal learning: Considering that our personality is the product of our interactions with other significant human beings, the awareness of the impact that we have on each other, is experienced and learned in our interpersonal relationships such as a group setting.

Group cohesiveness: To be able to share one's inner world, to be accepted by others, to feel to be a valuable, integral participating member of a group, fosters therapeutic change.

Catharsis: Learning how to express feelings and not bottling them up.

Existential factors: Learning to take responsibility for choice and decisions made in life, and to face up to the basic issues of life and death.

When the question is asked "What is the task of the therapy group?" most individuals in psychotherapy groups come to value; their acceptance of the patient role; that they were able to engage in self disclosure; their honesty about feelings towards self and others; non defensiveness; a renewed interest in and acceptance of others; the support of the group, and achieving personal improvements (Yalom, 1975).

3.9.2 Gerard Corey's Contribution to Multicultural Group Therapy

Corey (2000, 2004), and Corey and Corey's (1997) contribution to group psychotherapy sheds light on the multicultural dimensions, and the ethical, professional, and legal issues involved in the practice of counseling and psychotherapy. Corey (2000, 2004) also presents an overview of twenty-two group leadership skills, including active listening, empathizing, goal setting and terminating skills, which may be used in any multicultural group setting. The practical aspects of the multicultural, ethical, professional, and legal issues of how group psychotherapy was conducted in the present ethnographic inquiry will be discussed from Chapter 4 onwards.

3.10 CONCLUSION

In this chapter I have conveyed my understanding of, and how I have grasped, the general principles in the field of psychotherapy, which has flowed into my teaching and training of students. It is interesting to note that more than fifty years ago, Porter (1950) encouraged therapeutic counsellors to distinguish between *therapeutic skills* (techniques), and *therapeutic attitudes*. This basic attitude and approach to psychotherapy still remains the same today. It is also interesting to note that regarding *psychotherapy providers* of the future in the U.S.A, it is predicted that *self help groups* top the list, followed by psychiatric nurses, master's level social workers and psychologists. Following on in the list are nine more future psychotherapy providers with psychiatrists forecasted to be at the bottom of the list (Norcross & Freedheim, 2003). Psychotherapy unlike medication, is also beneficial, effective, and necessary with people in everyday walks of life, not only for the mentally ill, as is the case for psychiatric medication. Psychotherapy affords an opportunity into a person's life experiences, an inroad into the reality of how the person experiences aspects of her/his life. Today's society is full of people who find themselves in all sorts of circumstances: unexpected illnesses, financial struggles, employment issues, relationship difficulties, situations of injustice, brushes with the law, experiences of vulnerability and failure, bouts of boredom, and grapplings with faith. These situations are complex and unpredictable. In mysterious ways they cause people to plumb the depths of the spirit, searching for peace, or at least relief (Hermes, 2007).

Within the framework of ethnography, the remainder of this thesis deals with how psychotherapy aligns itself with the many multicultural influences experienced in the hospital. The interaction of psychosocial, biological, and cultural influence in the assessment of health

and illness and the course of psychological treatment is inquired into. The thesis also focuses on the current issues of multicultural concerns within the hospital, with populations such as specific language groups, ethnic background, gender, refugees, and with the integration of traditional and all modern forms of psychotherapy and healing.

CHAPTER FOUR

INITIATING STUDENTS INTO THE CULTURE OF THERAPEUTIC PSYCHOLOGY

The way in which psychological treatment is presented in novels (Green, 1964; Kesey, 1962; Rosten, 1961; Schreiber, 1973), movies, even text books and classrooms, is not the same as in practice. In real live situations, the events that occur in psychotherapy, and the really decisive moments that take place, as every patient or therapist who has experienced them knows, "*…are unpredictable, unique, unforgettable, always unrepeatable, and often indescribable*" (Laing, 1974, p. 47). During the Medunsa selection process, students from many South African Universities with different theoretical backgrounds, apply to do the MSc Clinical Psychology course. During their internship year many students remark that they find it difficult to translate their theoretical knowledge into practice. A frequent remark made by the interns, is that role-playing is vastly different from interacting with a real patient in a real psychotherapeutic setting. Unlike the broad theoretical contents relating to psychotherapy as expounded in the previous chapter, in the present chapter and in Chapters 5 to 8, I will outline eight specific theoretical approaches of which I typically share with intern-psychologists during their internship training and supervision at the hospital. My personal attitudes about each theoretical approach at the beginning of each section are meant to encourage dialogue with interns. Because interns have been required to demonstrate their knowledge in ecosystemic psychotherapy in their written and oral examinations, I encourage them to keep an open mind during their internship year, by acquiring knowledge and practical skills belonging to all eight theoretical approaches.

4.1 Theoretical Perspectives in Psychotherapy

In this chapter the challenge will be, to *connect* the natural everyday group sharing activities in the hospital, to the theoretical issues of psychological *treatment* and *training*?

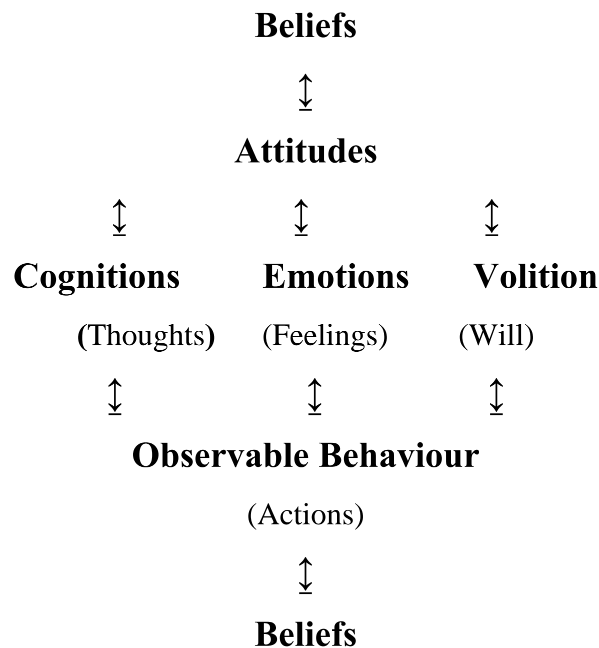
The challenge then is how to move from my personal experiences and observations, to the general theories and models of treatment and training. In doing so I will endeavour to reconcile the tension between the realities of what happens in the hospital, and the ideal as presented in the theoretical models used. By remaining rooted in the reality experiences of the hospital, I propose to relate to the eight theoretical approaches used, and show how the main aspects of the theoretical models have been effective in the practical application thereof.

Relating and linking the experiences outlined in this and the following chapters, to theories of psychotherapy, and taking cues from how psychotherapy has evolved over the past 120 years, (Bergin & Garfield, 1994; Freedheim, 1992, 2003; Lambert, 2004; Zeig, 1987, 1992, 1997), and the many multicultural aspects of psychotherapy (Corey, 2000, 2001, 2005; Moodley & Palmer, 2006; Multicultural Psychotherapy Associates, 2004, 2006; Prochaska & Norcross, 2007), the following **eight** broad therapeutic models will be referred to. Also, keeping in mind Bergin and Garfield's (1994) reminder to clinicians that, "*…no single profession has a monopoly on the field of psychotherapy nor can any group clearly demonstrate a consistent superiority in efficacy over all other groups*" (p. 5), the following eight broad therapeutic models capture the essence of what is generally accepted in psychotherapeutic circles globally. The psychotherapeutic approach as practiced at Weskoppies and Dr. George Mukhari Hospitals include an understanding of the principles, assumptions, and techniques of the following eight approaches:

- The Psychodynamic Approach.
- Behaviour, Cognitive, and Cognitive Behavioral Approaches.
- Person-Centered Approach.
- Existential Approaches.
- Gestalt Therapy Approach.
- Group Therapy Approaches.
- The Ecosystemic Approach.
- Integrative Therapy.

All theories of psychotherapy emphasise one or more of the constructs illustrated in Figure 4.1 below. Figure 4.1 is an illustration of how some commonly used concepts and constructs may be interrelated. Naturally, like any schematic representation, this illustration is only an approximation of the true psychological situation.

Figure 4.1 Linkage between Core Constructs in Psychotherapy



All the divergent theories, and conceptual approaches, offer guidelines to psychotherapists to decide *what to observe* and hence what to do with the observations. In general terms there are two opposing points of view about how to *decide what to observe* in nature. Albert Einstein for example has stated that firstly we need to create a theory in order to decide which facts to observe, while Sherlock Holmes was convinced that we first need to see the facts before we can create a theory (Messer & Wachtel, 1992). Both points of view are valid in attempting to make sense out of human nature and human behavior, especially when we realise that our thoughts, feelings, beliefs, attitudes, values, motives, and actions inextricably influence each other. In essence, our attitudes

and our actions are what will make the difference in how we relate to ourselves and to the people in our environment.

It is not my intention, nor is it possible to summarise all aspects of the following therapeutic approaches. My aim is to highlight only some key features of the therapeutic approaches with relevance to how it is applied within the Weskoppies Hospital culture-sharing therapeutic community. In any multidisciplinary context an integration of the *intrapsychic* (body and mind), and the *interpsychic* (interpersonal and intercultural) aspects, of the patient's functioning needs to be understood, when deciding upon the patient's rehabilitation process (refer to Chapter 1 Section 1.2.10).

4.2 The Psychodynamic Approach

I remember when I first read Freud's (1976) work on dreams, how fascinated I was by how complex and unpredictable the mind could be. The language of symbols and the power of the unconscious mind, motivated me to record my dreams on a daily basis for several years, many of which I discussed with my therapist, as I was undergoing learning therapy (leerterapie) during my BA Honours years.

I would like to introduce the psychodynamic approach by quoting what Sigmund Freud (1856-1939), the founder of psychoanalysis, once said in private correspondence in 1928, eleven years before his death: *"Why was it that none of the pious ever discovered psychoanalysis? Why did it have to wait for a completely Godless Jew?"* (Stafford-Clark, 1973, p. 14). In this one short statement, Freud's verbal behaviour reflects his beliefs, attitude, thoughts, feelings, and motivation, towards God, spirituality, piety, Judaism, and psychotherapy. Freud's personal life was apparently relatively uneventful, but his ideas have shaped the intellectual climate of many disciplines in the past century.

The psychodynamic approach refers to Freud's (1976, 1979) psychoanalytical treatment methods based on his psychoanalytic theory, as well as the work carried out by his followers, such as Jung (1963), Klein (1946), Sullivan (1953) and many others. The

psychodynamic approach emphasises mainly the intrapsychic (intrapersonal) aspects of an individual's functioning. When inspecting Figure 4. 1 above (p. 66), the psychodynamic approach would deal with *all* aspects of a person's functioning namely, beliefs, attitudes, cognitions, emotions, volition, and the symptoms manifesting in the observable behavior.

In the Weskoppies setting, by focusing on how the patient is repeating his *early childhood* in his present relationships, I am able to see how he brings his past relationships with significant others, particularly his father, into the session with me. When it becomes relevant I focus on his feelings towards me, because working with the phenomenon of *transference* is one way of attaining insight. I am also interested in the patient's *dreams*, any *resistance* that he shows, and any other clues triggered by his *unconscious processes*, which I assume may have a bearing on his present functioning. Allow me to share a portion of my feedback given to an intern after one of my recent live supervision sessions:

"I would like to emphasise one important aspect of the psychotherapeutic *relationship of trust*, namely the occurrence of *transference*. Corsini and Wedding, (1995, 2005) have described transference as the emotional bond that develops between the client and the therapist, or between the client and other significant patients. Another description of transference which I came across recently, is given by James Hillman (in Bader & Pearson, 2006a) who defines transference as '*…that which arrives to replace a real relationship*' (p. 2).

"I would like to focus on the nature of the phenomena that *arrives which replaces a real relationship*. As frequently observed in our ward rounds the patient shows his disappointment when her/his high (often unrealistic) expectations are not met. The disappointment may have to do with circumstances surrounding the therapist's skills, the patient's expectations, the treatment process, or the discharge procedure. The disappointment becomes the focus of discussion during the ward round, or during the therapeutic session at that stage of his treatment, and if the patient is not allowed to speak

about his anger, frustration, and helplessness surrounding his disappointment, or if the therapists involved are not equipped to deal with the situation then a stalemate occurs. Consequently the rehabilitation process becomes stuck, leading to the immobilization of growth and hope in the patient.

“What normally happens at this stage of the stalemate, is that the therapist (or mental health worker) takes the easy way out and uses her/his power and authority, by attaching a label to the patient, and influencing the other staff members that the patient is either relapsing, negative, oppositional, aggressive, showing no insight, or manipulative. At this stage, *something has arrived to replace a real relationship*. The *something* that has arrived in the relationship which has replaced the real relationship may be referred to as *transference,* (on the patient’s part) *counter-transference* (on the therapist’s part) and/or *projective identification* (again on the patient’s part). We generally regard *transference* as the impact that the other person’s communication has on us as therapists, while *counter-transference* may be seen as our ability or inability to understand, absorb, and respond effectively and appropriately to the other person’s communication.

“Transference and counter-transference can be either positive or negative. For many patients, transference may be embedded in another unconscious process known as *projective identification*, a concept coined by Melanie Klein (Klein, 1946), and discussed by many others such as Waska (1999), of which the therapist may be aware or unaware of. For staff members however, who are not adequately trained to recognize these unconscious processes, their counter-transference (positive or negative), which they communicate unconsciously, may take on the form of power tactics. On the other hand, clinical psychologists while under their internship supervision, undergo transference experientially. Clinical psychologists have been trained to ask questions about the reciprocal impact in the interaction between therapist and client during their psychotherapy supervision training, which is not generally the case with other health professionals. Therefore closely related to t*ransference* is the phenomenon of *projection* and *projective identification*. The following summary given by Anyara-Essays, (2004) neatly sums up the situation of projection.

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"The term 'projection' according to Carl G. Jung designates '... quite correctly the illusion and unconscious assumption by which I ascribe to my fellow man what largely belongs to myself. I lodge it in him, so to speak'" (p. 1).

"Projective identification is thus a psychological process that can happen between any two persons, especially when one of the two partners has a deep inner need to get rid of some of her or his own parts. When such a person finds a good projection target he or she dumps all those unwanted parts onto (actually ***into***) the other person. Projected qualities are not always negative, even our good qualities may get buried deep within and then projected out (into the therapist) without our conscious knowledge."

The psychoanalytic approach to the understanding and treatment of mental illnesses has been the most commonly used approach since the start of Weskoppies Hospital; even the street names signify the initial Freudian influence (refer to Chapter 5, Section 5.8). The psychodynamic influence is particularly evident in the psychometric testing and evaluation of observation cases in Ward 23 which will be referred to in Chapter 8 of this thesis.

Getting back to Freud's comment at the beginning of this section, I am not sure how Freud ever responded to his statement about being a Godless Jew discovering psychoanalysis, or how his friends, family members, or colleagues responded. It is however self-evident that Freud asked many other questions about himself and his theory of psychoanalysis. One can only speculate how pleased or displeased he would be to see how psychotherapy has developed over the past 100 years.

4.3 Behaviour, Cognitive, and Cognitive Behavioural Approaches

Initially I was not impressed with behaviour therapy. I found it to be too ordinary, simplistic, and mechanical. I however soon overcame my arrogance towards behaviour therapy when I realized the effectiveness of how relaxation exercises, autogenic training, and self-monitoring tasks reduced and even eradicated negative symptoms. I was

particularly influenced by the practical and clear guidelines outlined in the behaviour therapy text book by Walen, Hauserman, and Lavin, (1977).

Burrhus Frederic Skinner (1904-1990), is not a typical behaviour psychotherapist, but rather a renowned researcher in behaviourism. I just happen to enjoy the topics that he addresses in his writings from a behaviourist's point of view. Issues such as freedom, dignity, values, culture, and the question, 'What is man?' may equally belong to the school of phenomenology and existentialism. In his last book Skinner (1976) asserts that: "*We have used the instruments of science; we have counted and measured and compared; but something essential to scientific practice is missing in almost in all current discussions of human behavior. It has to do with our treatment of the causes of behavior*" (p. 13). In contrast to this statement behavior therapy is not really interested in the cause of mental disorders, but rather in how to remedy the problem.

The philosophical roots of behaviour therapy can be found in the school of behaviourism, which states that psychological matters can be studied scientifically by observing overt behavior, without discussing internal mental states (Rimm & Masters, 1979; Yates, 1970). The *behavioural model* thus focuses only on observable behaviour. The *cognitive behavioural model*, as developed by Beck (1976, 1995) however, also addresses intra and interpersonal issues of our psychological functioning. When inspecting Figure 4. 1 (on page 66, the behavioural approach would focus mainly on the observable behavior, while the cognitive behavioural approach would focus mainly on the beliefs, cognitions, emotions, and observable behaviour aspects of the person's functioning.

It is generally agreed that theories of psychotherapy can be evaluated, discussed, and criticised on three levels, namely, as a sound *theory,* as useful guidelines for *treatment,* and as conducive for *research.* Behaviour, cognitive, and cognitive behavioural therapies have been subjected to, and have had the most published research carried out on them on each of the three levels.

Progressive relaxation, autogenic training, systematic desensitization, role playing, assertion training, hypnotherapy, guided imagery, cognitive restructuring, flooding,

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implosion, symptom monitoring, assigning tasks and homework are accepted and commonly used techniques in behaviour, cognitive, and cognitive behavioral therapies (Corey, 2005; Prochaska & Norcross, 2007; Walen et al., 1977; Wolberg, 1977).

In behaviour therapy as implemented at Weskoppies Hospital, a thorough assessment of the patient's current observable behaviour is conducted. Sometimes the patient is asked to monitor his activities so that baseline data can be created in order to evaluate any visible changes. In collaboration with the patient concrete goals are created. New coping skills are constantly taught in the therapy sessions, often through role playing and the patient is encouraged to use the skills in his everyday situations.

In cognitive behaviour therapy the focus is on how the patient's internal dialogue and thinking processes influences his behaviour. An active and directive therapeutic style is used. Therapy sessions are present-centered, time limited, and structured. The patient's self-defeating and self-handicapping *beliefs* are explored, inquired into, and challenged. This is done as follows: The patient is encouraged in collaboration with the therapist (the therapeutic alliance) to work out how his cognitive triad of *negative automatic thoughts* (NAT's) are attached to his beliefs (intermediate and core beliefs). Techniques used may include role playing, modelling, coaching, assertion training, completing homework assignments, and relaxation methods. (Beck, 1995; Corey, 2005; Hollon & Beck, 1994).

Regarding transference reactions (*that which arrives to replace a real relationship*), in the context of common therapeutic processes found in diverse approaches, Beck (in Marmor, 1987), explains that by pinpointing *the thought preceding the feeling* expressed by the patient which triggers the transference reaction, can rapidly get at the material that is relevant to the transference reaction in a much shorter time than by questioning and probing. Beck's daughter Judith Beck (Commitment, 2007) explains how thoughts precede emotions: "*Individuals interpret situations in various ways and react emotionally in accordance with that interpretation. For example your friend is late. If you think, 'She must not care about me,' your emotional reaction is likely to be one of sadness. If you think, 'What if something terrible happened to her?' you are likely to feel anxious. If you*

think, 'How dare she keep me waiting!' you will probably feel angry. Your perceptions, in the form of your thoughts, influence your emotional reactions" (pp.4-5). Beck (in Zeig 1987) clarifies the importance of the therapist's awareness of his/her own feelings and thought patterns which influences therapy outcome. *"So that's the second point I want to make about transference. I certainly believe one should be aware of it as much as possible. It plays an important role in understanding the patient. There is another thing we should keep in mind about transference reactions. …If you're not aware of the way the patient reacts toward you, the whole therapy can become counterproductive"* (p. 276). It is reassuring to note that when the understanding of a psychoanalytical term like *transference* is truly grasped, then it can be observed in any interpersonal interaction, as clearly illustrated in the above quote by Beck (in Zeig 1987).

The concept of *behaviour modification* traditionally belongs to behaviour therapy. In the Weskoppies Hospital setting the concept of *behaviour modification* has very often been used as an excuse for *punishment*. Behaviour modification as understood by clinical psychologists, explained and taught by psychiatrists, and implemented by nurses, especially by the night staff, and weekend staff, has led to much debate and confusion, and has been counter therapeutic to patients. This confusion seems to be the projections that health workers place on their understanding of the concept of behavior modification. Based on the idea of *reward* and *punishment* the emphasis rather is supposed to fall on *reinforcement* and *extinction*. The principles of the *token economy system* worked for a while at Westfort hospital in the early 1990's (referred to in Chapter 6 Section 6.3). Currently in the Weskoppies setting, *behaviour modification* has become a matter of arbitrary assigning and withdrawing privileges, which has different implications in reality. For example patients are:

- kept in their pyjamas;
- not allowed to visit the tuck-shop;
- not allowed to attend occupational therapy;
- not allowed to attend group therapy;
- kept in seclusion;
- transferred to closed ward for at least three months.

In the hospital system wrong, dysfunctional, unrealistic, and faulty behaviours are often reinforced. For example the patient's dagga use, assertive behaviour, and compliance has often led to contradictory and paradoxical ways of understanding such behaviours on the part of patient and staff alike. Misunderstandings and confusion arises, which detracts from a real relationship, resulting in the very strong likelihood of projection, transference, and counter- transference to take place.

Behaviour therapy, cognitive therapy, and cognitive behavioural therapy are used in open as well as closed wards (discussed in Chapters 6, 7, and 8), to treat depression, anxiety disorders, phobias, and related forms of psychological disorders.

Two other behavior psychotherapists deserve to be mentioned, namely, Joseph Wolpe (1915-1997) who developed and researched the technique of systematic desensitization, and Arnold Lazarus 1932-) who developed multimodal therapy, both who were born in South Africa and graduated at Wits University. Perhaps Wolpe's most important contribution to clinical psychology and psychiatry, was that he managed to combine two seemingly disparate disciplines. Many psychologists and psychiatrists were of the opinion that methods based in applied science lacked the humanistic touch they felt was so important when dealing with people. What Wolpe (1958, 1969) did was to show that effective, compassionate therapy could be combined with empirical methods in a way that used both methods to their best advantage, namely systematic desensitization. Among his writings, his books *Pyschotheraphy by Reciprocal Inhibition* (1958) and *The Practice of Behavior Therapy* (1969) are considered classics in behavior therapy studies (Milite, 2007). I am not sure if Joseph Wolpe and Arnold Lazarus ever work at, visited, taught, or referred patients to Weskoppies Hospital? I cannot find anything in the available literature, or in the currently available Weskoppies archives.

4.4 Person-Centered Approach

Rogers's (1951, 1967) self theory and his theoretical approach made sense to me from the start. The fact that the therapist's attitudes of empathy, acceptance, and congruence could be cultivated and measured, and was also extensively researched, encouraged me to

practice these therapeutic attitudes in all initial interviews. I received constant feedback from patients of how easy it was for them to open up and to get in touch with their thoughts and feelings.

Client-centered therapy initially known as non-directive psychotherapy, and currently known as Person-centered approach (PCA) is synonymous with Carl Ransom Rogers (1902-1987). The clarity with which Rogers (1967) explains the impact and relevance of one's **personal experience** still resounds loud and clear today: "*Experience is, for me, the highest authority. The touchstone of validity is my own experience. No other person's ideas, and none of my own ideas, are as authoritative as my experience. It is to experience that I must return to again and again, to discover a closer examination to truth as it is in the process of becoming in me.*
"Neither the Bible nor the prophets – neither Freud nor research – neither the revelations of God nor man – can take precedence over my own direct experience. …My experience is not authoritative because it is infallible. It is the basis of authority because it can always be checked in new primary ways. In this way its frequent error or fallibility is always open to correction" (pp. 23-24). Rogers's statement although different in content to Freud's (see Section 4.2 above), strongly reflects his own beliefs, attitude, thoughts, feelings, and motivation, towards God, authority, Freud, truth, spirituality, research, and particularly subjective experience.

The Person-Centered Approach which is commonly grouped under the heading of the Humanistic Approaches, addresses intra and interpersonal aspects, if and when necessary, and therefore often reaches a client on a deeper level than what the behavioural and cognitive approaches do. Each person is regarded as having unique qualities and the freedom to express and explore her/his own growth potential. Therapy sessions are neither structured nor planned, and the client is trusted to find her/his own direction at her/his own pace. Given positive regard, clients are free to discuss whatever they want in the therapy sessions. The therapist's main responsibility is to be *real* and accepting of the client's feelings and thoughts, without conditions and without judgements. The therapist achieves this *realness* by acquiring the qualities of *unconditional positive regard*

(acceptance), *accurate empathy* (empathic understanding), and *genuineness* (sincerity). Therapeutic empathy, warmth, and genuineness create the *real*ness in the therapeutic process, in which transference does not become a significant factor in the therapy process.

A core theme in Rogers's theory is the necessity for non-judgemental listening and acceptance if clients are to change (Corey, 2005). This core theme of non-judgemental listening and acceptance, works wonders in the initial interview with patients in the hospital. It however requires great and constant effort, because State Patients have mostly felt judged up until their first therapeutic encounter, resulting in some patients to take advantage of being really listened to, which may elicit their manipulative ploys, causing distrust and ridicule in 'experienced staff', who ruthlessly confront the patient with his/her 'lies'.

Corey (2005) cites the work of Hubble, Duncan and Miller, (1999) regarding the *areas of application* of PCT which is effective with a wide range of problems, including anxiety disorders, alcoholism psychosomatic problems, agoraphobia, interpersonal difficulties, depression, cancer, and personality disorders. Corey (2005) adds that "*Person-centered therapy has been shown to be as viable as the more goal-oriented therapies. Furthermore, outcome research conducted in the 1990's revealed that effective therapy is based on the relationship with the therapist and the client, in combination with inner and external resources of the client*" (p. 176).

In the Weskoppies Hospital setting the inner resources of the patient refers to his physical, emotional, and cognitive abilities, while the external resources of the patient refers to all the hospital, community, and family (home) resources. In the Medunsa Firm context at Weskoppies Hospital, initial encounters with patients are conducted in a person-centered manner which much success. Because Rogers's theory rests on the assumption that clients can often understand the factors in their lives that are causing them to be unhappy (Corey, 2005), group psychotherapy at Weskoppies Hospital sometimes becomes more directive, when clear guidelines and directives are given to,

and sometimes expected by patients. The information is given with a person-centered stance. For example transfer to an open ward, and discharge procedures would be clearly spelled out and discussed within the following framework adopting a person-centered stance:

Transfer and Discharge Procedures

1. Adherence to medication.

2. Improvement in behavior.

- No smoking of dagga;
- No gambling;
- Show assertive behavior, e. g. request instead of demand, no fighting, no threats, be cooperative with fellow patients, ward staff, and other members of the multidisciplinary team.

3. Respect: Be aware of patient's rights and responsibilities e.g. ward rules, hospital rules, be punctual for medication and ward rounds.

4. Have a custodian: develop a good relationship with your custodian.

5. Successful leave.

6. If patient is successful with the above, the conference will discuss the case and make a decision to discharge the patient in collaboration with the Attorney General's Office.

Keeping in mind, that although it is important to grasp the world of the client and reflect this understanding, *reflection of feeling* can become a stereotypical way of simply restating what the client has said, especially with trainee therapists, in which case is *not empathy*. Rogers (1951, 1967) has always emphasised the relationship with the client as being central. Corey (2005) highlights the importance hereof: "*Rogers's contention that the therapist's relational attitudes and fundamental ways of being with the client constitute the heart of the change process*" (p. 174).

Referring to multicultural aspects globally, Cain (1987) sums up the far reaching extent of the person-centered approach to cultural diversity: *'Our international family consists of millions of persons worldwide whose lives have been affected by Carl Rogers's*

writings and personal efforts as well as his many colleagues who have brought his and their own innovative thinking and programs to many corners of the earth' (p. 149).

Linking Rogers's global contributions with the emphasis on the core conditions (empathy, warmth, and genuineness) of the person-centered approach makes the approach useful in understanding diverse worldviews. Corey (2005) clarifies: "*The underlying philosophy of person-centered therapy is grounded on the importance of hearing the deeper messages of a client. Empathy being present, and respecting the values of clients are essential attitudes and skills in counseling culturally diverse clients. Therapist empathy has moved far beyond simple 'reflection,' and clinicians now draw from a variety of empathic response modes (Bohart & Greenberg, 1997). This empathy may be expressed and communicated either directly or indirectly*" (p. 179).

Glauser and Bozarth (2001) maintain that the *empathic stance* is the essential part of the client-counselor relationship and that "*…the real determinant of any particular client's culture is that of the client's perception*" (p. 144). Thus paying attention to the cultural identity of the client requires an empathic stance as well as being perceptive and sensitive, while entering the client's world. In practice this means that therapists should not make assumptions about clients based on the client's cultural background or the specific group to which they belong. The therapist should wait for the cultural context to emerge from the client. Therapists are also cautioned to be aware of the *'specificity myth'* which leads to specific treatments being assumed to be the best for particular groups of people. The main message of Glauser and Bozarth's (2001) is that counseling in a multicultural context must embody the core conditions associated with all effective counseling. The authors state: "*Person-centered counseling cuts to the core of what is important for therapeutic success in all counseling approaches. The counselor-client relationship and the use of the client's resources are central for multicultural counseling*" (p. 146).

The counselor-client relationship and the use of the client's resources, become the foundation on which a *real* relationship is built. The client-counselor relationship deals

with the here-and-now issues, while the client's resources provide the tangible skills and material for dealing with everyday tasks and responsibilities in a realistic way, according to the client's capabilities.

Furthermore Corey (2005) explains that "*Person-centered therapy (PCT) has made significant contributions to the field of human relations with diverse cultural groups. Rogers has had a global impact. His work has reached more than 30 countries, and his writings have been translated into 12 languages. Person-centered philosophy and practice can now be studied in several European countries, South America, and Japan*" (p. 177).

Of all the multicultural psychotherapeutic contributions, person-centered therapy is most probably the approach which has contributed the most to people with diverse social, political, and cultural backgrounds. However Corey (2005) points out the following limitations if multicultural psychotherapy is practiced exclusively within the person-centered framework:

- Clients using community mental health clinics involved in outpatient treatment, want more structure, and can be put off by professionals that do not provide sufficient structure;
- It is difficult to translate the core conditions (empathy, warmth, and genuineness), into actual practice in certain cultures;
- Some ethnic groups (also religious groups) value collectivism more than individualism. The internal locus of evaluation (peoples own personal preferences) is not valued when social mores and expectations are the accepted values of the ethnic or religious group. However "… *a competent person-centered therapist understands, accepts, and works with a clients external world as well as a client's inner world*" (p. 180).

Closely related to Rogers's emphasis on *being with the client* is the therapeutic approach of Conrad W. Baars and Anna A. Terruwe (Baars1996; Baars & Terruwe, 1976; Terruwe, 1960; Terruwe & Baars, 1981). Conrad Baars and Anna Terruwe are two Dutch

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psychiatrists who are not cited much in academic circles, but have gained much respect in their therapeutic approach of *affirmation therapy*, which will be discussed in the latter part of the next section relating to existential psychotherapy.

4.5 Existential Approaches

Existentialism and phenomenology appealed to me because of their philosophical assumptions. I enjoyed the abstract ways in which human nature and behaviour could be explained and understood; despite the limitation that there are few clear guidelines as to how to apply the principles in therapy. I appreciated the acknowledgement of the spiritual dimension of humankind, and that a higher being (God) could be sought to obtain meaning, understanding, and assistance when appropriate; not as Sigmund Freud and Albert Ellis, who described religion (a form of spirituality) as being an obsession.

In 1949 Rollo May (1909-1994) received the first PhD in clinical psychology ever awarded from Columbia University in New York (Boeree, 2006; Zeig, 1987). Clinical psychology was still in its infancy days. May (in Freedheim, 2003) explains as follows: "*My memory goes back to the years of 1955 and 1956, when there were only a handful of us in the whole state of New York practicing psychotherapy. We thought of those as the 'dangerous years.' We few psychologists were continually under the threat of being declared outlaws in our conflict with the narrow wing of the American Medical Association (AMA). I recall those days when the legislature for New York was in session. We knew the legislators had before them a bill introduced by the conservative wing of the AMA that would make all psychotherapy a branch of medicine. If this passed, we would be explicitly outlawed and possibly arrested for practicing medicine. … For 6 or 8 years, intense anxiety visited me and my colleagues almost continually when the legislature was in session*" *(p. xxiii).*

It was at that time that Rollo May telephoned Carl Rogers in Chicago, whom he had not yet met, to get Rogers's ideas on licensing. Rogers was not sure whether it would be good or not to have psychologists licensed. For several years Rollo May kept thinking of Carl

Rogers's doubts about campaigning for licensing, when May eventually understood that "*There is a serious dilemma occurring in our vocation and in our practice of helping people with their personal problems. The question is, Are we training technicians or professionals?*" (May in Freedheim, 2003, p. xxiv).

Although May (1974) never developed a formal system of existential therapy he was regarded as the principal American spokesman of European existential thinking as it is applied to psychotherapy. May's view is that psychotherapy should be aimed at helping people discover the *meaning* of their lives and should be concerned with the *problems of being* rather than with problem solving (Corey, 2005; Prochaska & Norcross, 2007).

In essence, existential psychotherapy is more a philosophy about psychotherapy than a system of psychotherapy. Techniques and practical guidelines are secondary to the philosophical understanding of the meaning of a person's life, and to the process of becoming an active and meaningful entity in the world (being-in-the-world). Referring to the non-importance of techniques and guidelines Frankl (1978, 2004) however is noted for a technique called *paradoxical intention* (described in his theory of *logotherapy*) whereby the patient is encouraged or deliberately instructed to continue repeating his dysfunctional behavior, closely resembling what is commonly known as *prescribing the symptom* in systems therapy (Haley, 1963). In the Weskoppies setting, for patients who have been labelled as habitual absconders, this technique has been used successfully on many occasions. The full understanding and cooperation of all MDT members is required. Instead of restraining the patient in a closed ward for his 'bad behaviour' of absconding, the patient is placed in an open ward, and told that he may abscond if he wishes, because absconding is not his real problem (actually it isn't his problem because it is a hospital problem), and the patient is told that the team will address his real problem, which normally involves family matters. When family members are brought in to a ward round, it is remarkable how the patient's attitude and behavior changes for the better. When the patient realizes that he is taken seriously he also makes a serious attempt to cooperate with all team members. Frankl (2004) also appreciates the appropriateness of logotherapy and paradoxical intention in his assertion of "*A realistic fear, like the*

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fear of death, cannot be tranquilized away by its psychodynamic interpretation; on the other hand, a neurotic fear, such as agoraphobia, cannot be cured by philosophical understanding" (p.125).

Like the person-centered approach the existential approaches are also grouped under the heading of the Humanistic approaches in the literature. In existential psychotherapy the therapeutic relationship itself becomes the focal point and the source of generating relevant issues towards the patient, how he finds meaning in life, and if and how spiritual issues have shaped his attitudes and behaviours. (Corey, 2005; Frankl, 1963, 1978, 2004). It is generally accepted that people with sound spiritual foundations tend to be healthier and recover better when their lives turn for the worse (Blatner, 2005; Richards & Bergin, 2000; Scotton et al., 1996; Sperry, 2001; Sperry & Shafranske, 2005; Weiner et al., 2005).

Linking the *realness* of the therapeutic relationship as discussed in the psychodynamic section above, to the importance of *personal experience* discussed in Rogers's contribution (Section 4. 4 above), Frankl's (1963, 2004) theory of logotherapy assists the patient to find meaning in life. Frankl's (1963, 2004) contribution to psychotherapy which was gained from his experiences in the four concentration camps (including Auschwitz and Dachau), in which he was taken prisoner, has reintroduced *meaningfulness* and *religion* into therapy. The meaning of life, the meaning of the positive and negative experiences in one's life, and the purpose of one's life, are intimately tied up with Frankl's (2004) discourse of meaningfulness and religion; which are in turn related to one's spirituality. For Frankl (1963) love is the ultimate and highest goal to which man can aspire. "*The salvation of man is love and through love*" (p. 59). Frankl (2004) advocates a religious belief system, namely a belief in God.

Like Victor Frankl, Conrad Baars (1919-1981) referred to in Section 4.4 above, also spent time in a concentration camp. Baars (1996) spent two years in Buchenwald Germany, after being captured by the Nazi's while serving in the anti-Nazi underground in Belgium, France, and Holland. As a result of his personal experiences in the

Buchenwald (German for "*beech wood"*) concentration camp, Baars (1996) like Frankl (1963, 2004), realized the meaningfulness and usefulness of *suffering* and *conflict*, by turning suffering into a human achievement and accomplishment. Baars (1996) immigrated to the USA and as a result of his deep reflections on his personal experiences in Buchenwald, and in collaboration with a colleague Anna Terruwe who was practicing in the Netherlands, Baars and Terruwe (1976) and Terruwe and Baars (1981) crystallized the ideas underlying *affirmation therapy*. Their contention was that many neurotics had failed to respond to psychiatric therapy, because not all neuroses were caused by the repression of childhood emotions. Baars and Terruwe (1976) assert that certain neurotic symptoms develop when a person has been deprived of affirming love from significant others, and even "*…the lack of motherly love and tenderness-by itself would be sufficient to bring about a neurotic illness without the further action of a repressive process*" (p. 4). One of Baars's (1996) key insights while in the concentration camp was that: "*Evil flourishes because people no longer obey the laws and commands of God*" (p. 186). Like Victor Frankl, the importance of one's belief system is highlighted by Baars (1996), who lived by a *specific* belief system, namely Catholicism. Emphasising the theme of *human dignity*, Baars and Terruwe (1976), Rogers (1951, 1967), Frankl (2004), and The New Mental Health Care Act No 17 (2002), have emphasised the importance of respect, dignity, integrity, and worth in humankind.

In a different and not very well known context, the following two quotations place Conrad Baars and Anna Terruwe in the company of two other psychotherapists, namely, Abraham Maslow (Maslow, 1968) and Francis Braceland, the 85th president of the American Psychiatric Association.

"*After citing the genesis story of creation, in a presidential address to the American Psychiatric Association, Abraham Maslow remarked that the role of the psychiatrist was to restore man to God's image. Two essential areas of such a restoration are the psychological and the spiritual. Man's psyche or soul cannot be separated from his spirit. For too long a time, there seemed to exist a conflict between theology and applied psychology (whatever school). Fortunately, and especially since Vatican II, the clergy*

are turning to the resources of psychology, though sometimes at the expense of theology" (McCarthy in Terruwe & Baars, 1981, p. v).

In 1960 "*In his forward to the first American edition of Dr. Anna Terruwe's doctoral thesis*---The Neurosis in the light of Rational Psychology—*Francis Braceland, M.D., 85th president of the American Psychiatric Association, wrote: 'It is said that the love of God is an adventure of the spirit and the sad thing in our day is that there are few adventurers who, like Dr. Terruwe, are willing to soar intellectually. It is a delight to welcome her ideas…and evidences of original thinking as are exemplified in this book….Any psychiatric theory which takes into account the spiritual nature of man will be particularly welcome in many areas'*" (Baars in Terruwe & Baars, 1981, p. vii).

4.6 The Gestalt Therapy Approach

My attitude towards gestalt therapy was that I had to learn but another therapeutic approach. I also found that it necessitated the therapist to be more active, and confrontational. I did not feel comfortable with changing from the accepting and non-judgemental style acquired from the client-centered approach to a more active style. It slowly dawned on me that the therapeutic ingredients of empathy, understanding, and congruence could be imparted in a more active and benign confrontational way, without damaging the relationship of trust.

Frederich (Fritz) Perls (1893-1970) was the developer of Gestalt therapy. Perls lived in South Africa for 12 years, from 1934, before the rise of Nazism, to 1946, before the rise of apartheid. Born in Berlin Germany, where he was educated, he also received part of his psychoanalytic training, in Austria. Perls became very aware of, and anticipated the horrors of Hitler in the early 1930's. He became an early refugee from Hitler's regime in 1934, by responded to, and accepting Ernst Jones's offer of a psychoanalytic position in Johannesburg. Besides establishing a clinical practice, he also began the South African Institute for Psychoanalysis. Perls was influenced by the South African Prime Minister's (Smuts, 1926, 1987) ideas on holism and ecology. Over the next 12 years, he developed

what he considered a revision and an elaboration of psychoanalysis. With the rise of apartheid in South Africa, Perls again chose to leave South Africa, a country heading towards unacceptable oppression, in 1946 after his resignation and discharge from the South African Defence Force. He immigrated to the United States with his therapist wife, Laura, where he began the New York Institute for Gestalt Therapy in 1952. In the USA, Perls attended Jacob Moreno's open sessions in New York and was probably influenced by Moreno the psychiatrist, who founded psychodrama and who insisted on combining action with the verbal and cognitive aspects of psychotherapy (Blatner, 2005; Corey, 2005; JW, n.d.; Prochaska & Norcross, 2007).
Referring to the practicalities of gestalt therapy, Perls (Prochaska & Norcross, 2007) explained that in order to do psychotherapy, all he needed was the following:

- a chair for the hot seat;
- an empty chair for the client's role playing;
- a client willing to enter the hot seat;
- an audience or group willing to participate in the work between therapist and client.

Most of Perls's (Corey, 2005; Prochaska & Norcross, 2007) work especially in his famous years was done in workshops, lectures, and seminars, thus the emphasis on the audience or the group. In recent years gestalt therapy is still conducted in groups, as well as with individuals, couples, and families. The 'audience or group willing to participate' would be the client/s, couples, or families involved in the therapy itself.

Developed by Fritz Perls and his wife, Laura, in the 1940's gestalt therapy is an *existential-phenomenological* approach based on the premise that individuals must be understood in the context of their ongoing relationship with the environment. (Corey, 2005; Prochaska & Norcross, 2007) Gestalt therapy is considered to be *phenomenological* because it focuses on the *client's perceptions* (subjective experiences) and is *existential* because "*…it is grounded in the notion that people are always in the process of becoming, remaking, and rediscovering themselves*" (Corey, 2005, p. 192). The initial goal in therapy is for the client to gain *awareness* of what s/he is experiencing,

and an understanding of how s/he is doing it. By gaining awareness and understanding, by experiencing the process of how the awareness and understanding is happening, and by remaining in the here-and-now (present), is the focus of therapy. Change thus happens automatically. Gestalt therapy is flexible in its application and can be adapted in and to multicultural contexts. One of the advantages of drawing on Gestalt methods (experiments) is that these experiments can be tailored to fit the unique way in which an individual perceives and interprets his or her culture. In addition, gestalt methods (interventions or experiments) provide opportunities to initiate sensitive, creative, and tailor made interventions that can be used in any multicultural therapeutic context. The traditional gestalt method (intervention / experiment) of the *empty–chair* dialogue pioneered by Perls, modified and systematized by his followers, include the following: *the internal dialogue exercise; making the rounds; the reversal exercise; the rehearsal exercise; the exaggeration exercise; staying with the feeling; dream work* (Corey, 2005; Prochaska & Norcross, 2007). These methods can be used very effectively with culturally diverse populations if the interventions are timed appropriately. Because gestalt therapists approach each client in an open way and without preconceptions it becomes a particularly suitable method when working with clients from other cultures. Many clients who are exposed to, and are influenced by multiple cultures, such as in South Africa, experience an ongoing struggle to reconcile what appear to be diverse aspects of the many cultures in which they live. Gestalt therapy methods are particularly effective in helping people integrate these multiple polarities within themselves (Corey, 2005). An example of *the internal dialogue exercise, rehearsal exercise, the exaggeration exercise,* and *staying with the feeling* methods are illustrated in Chapter 6 Sections 6.5 and 6.6, in which the therapist's attentive listening, and the patients spontaneously acting out behavior, allowed two patients to gain more awareness and understanding in their *here-and-now* moments (contexts).

The following section deals with group psychotherapy. It is appropriate to mention at this point that Gestalt therapy as well as Transactional Analysis (TA), quickly adapted to group methods. For Gestalt therapy "*The group would become the stage for session-*

targeted individuals who would be encouraged (coaxed, persuaded, goaded) into expressing their feelings (resentments, longings, etc.)" (Rosenbaum, et al., 1992, p. 703).

4.7 Group Therapy Approaches

Initially I felt threatened with the idea of group therapy. After reading Rogers's (1970) book on Encounter Groups I was willing to admit to myself that with a responsible and sensitive group leader, I would become part of a therapeutic group before expecting patients to undergo group psychotherapy. My idea of a responsible and sensitive group leader became a reality only in 1985, when a psychiatrist who practiced only group therapy, was briefly employed at Westfort Hospital. Up until then I had been conducting group therapy according to my own understanding of what responsible and sensitive leadership should be like.

Jacob Levy Moreno (1889-1974), regarded to be the father of psychodrama, sociometry, role training, and group psychotherapy was born in Bucharest Romania, grew up and studied in Vienna where he obtained his MD in psychiatry in 1917, and moved to the USA in 1925 (Marineau, 1989). In his autobiography Moreno states that since the age of 4 he had the feeling that he was God, which continued through all his life. He was fascinated with the person of Jesus Christ (Marineau, 1989). "*One of Moreno's role models was Jesus*" (p. 145); and he saw himself in the same role as Jesus and lived as if he was God. Moreno had already challenged Freud's theory while he was still a medical student. In his autobiography Jacob Moreno recalls the following encounter with Sigmund Freud in 1912, five years before he obtained his MD. "*I attended one of Dr Sigmund Freud's lectures. Dr Freud had just ended his analysis of a telepathic dream. As the students filed out, he asked me what I was doing. I responded, 'Well, Dr. Freud, I start where you leave off. You meet people in the artificial setting of your office. I meet them on the street and in their homes, in their natural surroundings. You analyzed their dreams. I try to give them courage to dream again. I teach people how to play God. …Dr Freud looked at me as if puzzled and smiled'" (*(Marineau, 1989, pp. 30-31).

Irvin David Yalom (1931-) was born in Washington, D.C., of parents who emigrated from Russia shortly after World War I. He graduated from the Boston University School of Medicine in 1956. Yalom has developed his approach within the existential and the group psychotherapies paradigms. Although strongly existential, he sees himself more as a scientific positivist, and is passionate when affirming his strong belief in science, and his skepticism about non-material or spiritual understandings of life. In an interview in 1996 when speaking of matters of life and death, Yalom alluded to the future of psychotherapy as follows: "*And I tell myself that I don't want to belong to any more committees or teach anymore, because the field is becoming drugs, pharmacotherapy. The next generation of therapists isn't going to be trained for psychotherapy because the insurance companies aren't going to be paying for it any longer*" (Branfman, 1996, p. 1).

Traditionally psychotherapists have regarded groups to be ancillary or supplementary, rather than primary treatment methods. It is however interesting to note that regarding *psychotherapy providers* of the future in the U.S.A, it is predicted that *self help groups* top the list, followed by psychiatric nurses, master's level social workers and psychologists. Following on in the list are nine more future *psychotherapy providers* with psychiatrists forecasted to be at the bottom of the list (Norcross & Freedheim, 2003).

Group procedures and interventions will vary from group to group according to the leader's style (Rosenbaum, et al., 1992). The leader's style which is influenced by his/her training, experience, and personality, and the group membership composition, will determine the therapeutic goals, process, dynamics, and outcome of each group interaction. In turn, group process, dynamics, and outcome are influenced by a multitude of factors, which have been researched in many clinical settings involving patients with medical illnesses, trauma related disorders, panic disorders, obsessive compulsive disorders, social phobias, bulimia nervosa, group's for the elderly, substance related disorders, personality disorders, mood disorders, and schizophrenia (Burlingame, MacKenzie, & Strauss, 2004). With reference to the general observations and recommendations pertaining to research in group psychotherapy, in 1994 it was concluded that "…*the orderly evolution of knowledge in the group disciplines had*

produced evidence that group treatment was more effective than no-treatment, placebo-attention, and non-specific treatment comparison conditions" (Bednar & Kaul (1994) in Burlingame, et al., 2004, p. 679). Given this foundation, Burlingame et al. (2004) asks the question if the past decade of research has taken researchers and practitioners any further along the evolutional trail? The authors believe that the answer to this question is a qualified yes.

As indicated in Chapter 3 Section 3.9, in his classic text Yalom (1975, 1995, 2005) singled out *eleven core therapeutic*, or *curative factors* experienced in group therapy processes. Yalom's (1975, 1995, 2005) curative factors are frequently and significantly displayed in groups in the culture-sharing group of the hospital in the present study, in the group psychotherapy context. In another text, Yalom (1983) specifically deals with *inpatient* group psychotherapy issues which are the subject matter of the present study. Yalom (1983) believes that an *interactional focus* is the indispensable and imperative ingredient in all groups, "*…even those composed of psychotic, disorganized patients...* [because it]*…is important to help members interact with one another and to understand, and generalize from, that interaction*" (p. 19). The ongoing interaction (therapeutic and informal), between patients and the therapeutic personnel, enhances the ability of patients to relate to one another during their long hospital stay.

4.7.1 Instillation of hope

From their first day after admission into the hospital the State patients hope and seek for a transfer to an open ward and for their discharge (Hospital Diaries, 1994-2008). Newcomers to the weekly group sessions only want to talk about one thing, namely how to be transferred to an open ward, and how to get out of the hospital. Keeping in mind that many patients are unfamiliar with hospital and psychological procedures, group sessions are initially treated with caution by them, but very soon become a highlight in their treatment process. The *theme of discharge* has many other related themes which become the main theme discussed, once a topic is agreed upon. The following frequently asked questions generate the topic to be discussed for any particular session.

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"What happens if we don't have a custodian?"
"My custodian drinks, but I am not allowed to drink."
When my custodian fights with me then s/he says I am relapsing."
"Where will I get money from?"
"We need a disability grant when we leave here, because we are sick."
"What if the clinic at my home doesn't have my medicine?"
"Will the people at home respect me if they know that I come from Weskoppies?"
When they know that I am from Weskoppies they won't give me a job."
"I know my friends at home will force me to take dagga and alcohol again."
"I only see patients going on leave, but never discharged."
"Yes what about life after discharge? Here in the hospital we get food and clothes and we see on TV that there is no work out there. That's why people do crime."

Using the group leadership skills of active listening, restating, clarifying, and summarising (Corey, 2000, 2004) a theme is consensually decided upon.

4.7.2 Universality

In the hospital setting, patients have shown their feelings of relief when others in the group shared similar feelings, actions, and experiences as their own. In many cases because of their own ongoing interpersonal difficulties, and their feelings of isolation, and rejection, because of the crime that they committed, groups afforded the patient an opportunity to witness, and experience for themselves the relieving benefits of sharing.

4.7.3 Imparting of information

The didactic aspects and the imparting of information was often an implicit process in groups. As the weekly groups gained more cohesiveness and the instillation of hope increased more specific information was asked for, like for instance:
"Tell us the facts about AIDS."
"We want to know more about mental illness."

"What must we do to get a disability grant?"
"It is hard to lead a social life after hospital life. We want our community to accept us. What can we do?"
"How can we get the nurses to respect us as patients?"
"Tell us what we must do to get transferred to an open ward, and to get a discharge", in which case the guidelines relating to *Transfer and Discharge Procedures*
described in Section 4.4 above (p. 77) would be written up and discussed.

The *imparting* of information becomes a *sharing* of information with the psychologist initiating, clarifying, and directing the flow of information in the most optimally therapeutically way possible.

4.7.4 Altruism

It has been encouraging to see how patients became tolerant, even empathic when they witnessed the pain, suffering, and frustration of others in the group. Also when others in the group were selfishly manipulating, pretending, or not using their talents and skills to assist fellow patients, they were confronted by their contemporaries. Patients learned to appreciate the value of receiving through giving.

4.7.5 The corrective recapitulation of the primary family group

The technique of role-reversal has often been used in group therapy to bring about the corrective experience based in reality. This has been equally effective in maximum security, semi-closed, semi-open, and open wards. Rosenbaum, et al's. (1992) contention is still valid today: "*It seems that cultures have always employed group forms of treatment as corrective emotional experiences and as a means of mutual support. …the various group psychotherapies appear to be responsive to our persistent needs for inclusion and belongingness*" (p. 697).

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4.7.6 Developing of socializing techniques

The development of basic social skills is a part of social learning, and also a curative factor, in terms of preparing long-term hospital patients for leave of absence and discharge. *Role playing* has been found to be a means to equip the patient to deal with, ward rounds, stigmatization, communicating with family and community members, and seeking employment. Referring back to Moreno's influence on psychotherapy, not only on group psychotherapy, Blatner (2005) has the following to say, regarding behaviour therapy, cognitive therapy, cognitive behaviour therapy, and rational emotive behaviour therapy: "*Each of these therapies uses role playing to identify maladaptive beliefs, and each requires rehearsing and individualizing the integration of new attitudes and response patterns. Behavior therapy has long used role playing, rehearsal, modelling, and other methods without specifically noting their origins with Moreno in the 1930's*" (p. 408).

4.7.7 Imitative behaviour

The aspect of patients modelling themselves on other group members, and on the therapist was *not* visibly evident. The fact that patients adhered to group norms, was perhaps more an aspect of developing basic social skills. Although there was much discussion about dagga use and absconding being irresponsible behaviour, patients rarely identified with a role model in the group which they tried to emulate. Patients who came back from successful leave, and who joined the group for the day, tried to convince other group members the importance of good behaviour.

4.7.8 Interpersonal learning

The importance of interpersonal relationships, the corrective emotional experiences gained, and the group experienced as a social microcosm allowed aspects such as transference to be dealt with, and insight to be gained. Once again role-reversal was seen to be effective to experiment and explore aspects of interpersonal learning.

4.7.9 Group cohesiveness

Yalom (1995) explains group cohesiveness as "…*the attraction that members have for their group and for the other members*" (p. 67), and through the therapeutic group experiences, eventually realizing that "*We are all in he same boat*" (p. 67). In all wards, the themes of *respect* and *cooperating with each other*, elicited by patients, often achieved a level of cohesion in which they recognized that the progress of each individual depended on the other members, which in turn helped reduce their feelings of estrangement and isolation, thereby instilling hope that they all had an equal chance of obtaining leave and other hospital privileges.

4.7.10 Catharsis

The group therapeutic procedures were a means of building a stronger sense of cohesion and of identity. In these groups the most significant emotional experiences were consequently those of mutual support, the sharing of resentments against those who had mistreated them and the venting of feelings about their being admitted to the hospital. Besides cathartic release and bonding, the therapeutic goals discussed in the group, involved some kind of commitment to social action during and after the group.

4.7.11 Existential factors

The meaning of freedom, life, and death has been common themes in group sessions in all wards. These discussions often led to the realization that each patient is free to choose, and is responsible for his actions, whether in or out of hospital. An illustration of the content, process, and dynamics of a group interaction with an in- patient heterogeneous group in a psychiatric ward is given in Chapter 7, Section 7.3.

4.8 Ecosystemic Psychotherapy

I became interested in systems therapy at the time when family therapy gained popularity in South Africa. I attended *The First International Conference on Family Therapy in a Multicultural Society*, at Sun City in July 1983, when world famous family therapists such as Dr. Maurizio Andolfi and Dr. Carlos Sluzki were invited as guest speakers. I became a member of the South African Institute of Marital and Family Therapy for five years, attended regular meetings and seminars, and used the document of *Working with the Milan Method: Twenty questions* (Campbell, Reder, Draper & Pollard, n.d.), as a guideline when I worked with families during my 9 years of full-time private practice.

Karl Ludwig von Bertalanffy (1901-0972) born in a little village near Vienna, Austria, was a theoretical biologist, who later researched on comparative physiology, biophysics, cancer, philosophy of science, and on psychology. He was one of the first to apply the methodology of General System Theory, to psychology and the social sciences. General System Theory is a general science of 'wholeness' which postulates that in the natural and social sciences there is a general tendency towards integration. Followers like Gregory Bateson (anthropologist) Paul Watzlawick (psychiatrist) Jay Haley (psychologist) and many others, further developed the patterns of thinking and communication as currently applied in psychotherapy (Principia Cybernetica, 2005). In preparation for the celebration of Ludwig von Bertalanffy's 100th birthday, and in the context of the multidisciplinary theme of 'unity through diversity' (Davidson in Elohimjl, 2001) acknowledges that von Bertalanffy *"... advocated that we dare to broaden our loyalty from nation to globe and urged that we become patriots of the planet, endeavor to think and act primarily as members of humanity, and begin pledging our allegiance to humanity and to the earth on which we stand, one planet indivisible for all. 'We must begin protecting the individual and cultural identity of others'"* (p.2).

Intrapersonal, interpersonal, cultural, and social aspects are addressed in the ecosystemic approach. Starting off with a client-centered stance the therapist gradually gets to know more about the client's style of functioning and interacting. Using a person-centered approach, together with circular questioning, (questioning around a particular

issue/aspect) the following sixteen aspects/questions are explored starting in the initial interview (refer to Chapter 3, Sections 3.8.1 and 3.8.2). The following interaction between the therapist and the patient named Steve (a pseudonym) is used as an illustration. Next to each aspect/question I will give an example of what the therapist's written comment may be:

- **Give the context in which the observation takes place.**

Steve was seen in Ward 65 (a closed ward) in Weskoppies Hospital. He was referred from Dr. George Mukhari Hospital one month ago (e.g., 12 April 2006), has been seen by a doctor once since admission, and is on medication.

- **Where applicable, sketch the presenting problem.**

Steve says he feels depressed and frustrated because his wife and children do not visit him in the hospital. He says that headaches and constipation have started over the past week, something that he has never experienced before. Steve wants to be transferred to an open ward.

- **Describe the definition of the relationship between the therapist and the client?**

Complimentary. Steve accepts the follower role and acknowledges the therapist in the leader position. No symmetrical episodes were encountered.

- **At the end of the session does the therapist feel closer or more distant towards the client?**

Closer. Steve manoeuvred for closeness and understanding.

- **At the end of the session does the therapist feel confused or clear about the picture that s/he has of the client?**

Clear. Steve communicated in a logical and clear manner; there were no double messages, nor any contradictions.

- **At the end of the session does the therapist feel at ease or defensive towards the client?**

At ease. Steve is not threatening or pressurizing in the therapeutic relationship. He enthusiastically seeks feedback and information.

- **At the end of the session does the therapist feel acknowledged or rejected by the client?**

Acknowledged. Steve acknowledged me as therapist in my role. He has been communicating appropriately.

- **At the end of the session does the therapist experience the client as congruent or incongruent?**

Congruent. Steve's verbal expression matched his presenting manner.

- **In the client's system does s/he give empathy and does s/he receive empathy?**

In the therapeutic relationship Steve was able to give and receive empathy. However his expression of empathy is not adequately shown in all parts of his system. Limited empathy appears to be coming from his wife Lerato. His parents and his two children appear to be showing more empathy than before. Inadequate empathy appears to be forthcoming from his employer. When addressing the hospital system Steve shows

empathy to the day staff members, but not to the three night staff members in his present ward.

- **In the client's system does s/he give and receive confirmation and recognition?**

As with empathy Steve shows varying degrees of recognition to members in his system. Recognition from his system ranges from very limited to adequate. His wife Lerato and the night staff in his present ward show him the least recognition; his employer displays low levels of recognition; his parents and his two children have recently been displaying more confirmation; his maternal uncle Bongani shows the most confirmation.

- **Is the client in control of his/her environment or is the environment in control of the client?**

Currently Steve is attempting various strategies to increase the degree of control within the hospital environment. His enhancing level of control is observed in his assertive and goal directed manner of interaction.

- **Does the client effectively express her/his needs?**

Yes. Steve effectively expresses his needs in a logical, systematic and direct manner. He shows adequate self-awareness and can focus on problems that need addressing.

- **What is the client's degree of interpersonal rigidity?**

Steve shows moderate flexibility as evidenced by his ability to modify and adapt his communication according to the specific context. He communicates effectively with day staff members, fellow patients, with the therapist, other members of the multidisciplinary team, and with specific members of his family and work systems.

- **Does the client exhibit effective problem solving skills?**

Steve fluctuates between managing his problems effectively on the one hand, by using diverse strategies in the past, and open and direct communication in his present environment, and on the other hand managing his problems ineffectively by wanting to abscond because of the side effects of his present medication.

- **Does the client exhibit interpersonal insight including the circular nature of behaviour?**

Steve demonstrates an awareness of the circular nature of communication, because he acknowledges both his role and the receiver's role in the interaction.

- **Does the client exhibit the ability to meta-communicate?**

Yes. Steve shows the capacity to communicate about his own communication. He is able to explore and take an outsiders view of what he says.

Based on the above observations, a **hypothesis** about the patient's functioning is then made which may appear as follows:

Steve does not receive adequate empathy and recognition from parts of his family system which are characterised as being disengaged at the moment. The boundaries among family members are seen to be rigid and ill defined. Hence, Steve has manoeuvred for distance in his interaction with his wife, his employer and the night staff at the hospital as a method of coping with his experience of their disapproval of him (no empathy recognition and confirmation given by them). The distance in these relationships has manifested in Steve, feelings of self isolation and loneliness, but only in these three sub-systems of his environment. At present however Steve manoeuvres for assistance and guidance which encourages him to redefine the blurred boundaries in his family and work systems, thereby taking responsibility to manoeuvre for more appropriate closeness with

family members and work colleagues. Steve's interactional style may be described as an assistance and information seeking style. Concrete therapeutic goals in his overall treatment plan will be decided upon after the next MDT meeting to receive and give input into Steve's all-round functioning.

At this point of the discussion it is worth mentioning that the information obtained from the IPA has much in common with the clinical information obtained from the DSM-IV-TR (2002). In the IPA however, the emphasis is placed on the present here-and-now observations and the client's subjective interpretation of his/her experiences, and not so much on background and collateral sources as is the case with the DSM-IV-TR (2002).

Linking once again to the construct of transference, clinical psychologists while under their internship supervision, undergo transference experientially. In ecosystemic language the client's transference behavior is referred to as a manoeuvre for something. The client's behavior may be described as manoeuvring for *sympathy*, *emotional distance*, *emotional closeness*, *sexual closeness*, *provocation*, *acceptance, understanding*, to name a few ways (manoeuvres) in which transference may be observed in the interaction. The above 16 questions have the same value as asking "What has arrived in our relationship which has replaced *a real relationship* between me and the client?" The above IPA questions just expand and describe the dimensions of the influences that have *replaced a real relationship*.

4.9 Integrative Psychotherapy

There are many contradictions in psychotherapy. There are well over 400 different psychotherapeutic approaches, each believing in its superiority over other types of psychotherapy. There is little evidence however that any one approach is more effective than the other (Bergin, & Garfield, 1994; Corsini, & Wedding, 2005; Lambert, 2004). It has long been recognized that the majority of practicing psychotherapists do not identify themselves with any one school of thought or approach, but describe themselves as being eclectic or integrative (Arkowitz, 1992, p. 261).

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As a response to the many contradictions, the field of *psychotherapy integration* has emerged as a coherent force commonly known as *integrative* psychotherapy based on a transtheoretical model (Norcross & Goldfried, 1992; Prochaska & Norcross 1999, 2003, 2007). It has also become evident that the previous notion of eclecticism actually may be a stage in the development of a more refined and efficacious type of psychotherapy (Bergin & Garfield, 1994; Corey, 2005).

For example "*Surveys suggest that most professionals in North America prefer some form of eclecticism* (many references are given). *The empirical analysis and merging of behavioral and cognitive perspectives are the most notable examples. But leaders of this movement have also come from a diversity of other schools of thought. They prefer the term integration over eclecticism because integration implies a more systematic use of concepts and techniques from different approaches*" (Lambert, 2004, pp. 805-807).

The challenge of developing an integrative perspective is to be attentive to the obvious trap of attempting to mix theories with incompatible underlying assumptions (Corey, 2005). Prochaska and Norcross (2007), however give much emphasis to the *transtheoretical model* which has been evolving for the past 25 years. In what Prochaska and Norcross (2007) call *Towards a Transtheoretical Therapy*, (pp. 507-8) some of the following statements describe the rationale of the model:

- Each psychotherapy system has its shortcomings;
- Psychotherapy cannot depend entirely on empirical research;
- No single system of psychotherapy has cornered the market on effectiveness;
- In the integrative spirit, a model of psychotherapy and behavior change is constructed, that can draw from the entire spectrum of the major theories; hence the name transtheoretical;
- Transtheoretical therapists make an epistemological commitment more than an ethical commitment;
- The transtheoretical therapist, then, is a relativist operating under a structure of ethical and epistemological commitment;

- “*As a body of essential knowledge for psychotherapists becomes identified, there should be no competing theories*” (p. 505);
- A relationship of trust remains the core of every therapy model. “*The transtheoretical therapist will be empathic, supportive, and responsive. However, this type of support and the therapy relationship will be tailored to the patients' stage of change*” (p. 529).

4.10 The Psychotherapist as a Role Model

Two themes have emerged in the aforementioned sections. Firstly, all the theorists which have been mentioned have been exposed to *diverse cultural backgrounds*; Western Europe (Freud, Jung, Perls, Baars, Terruwe); Eastern Europe (Moreno, Yalom' parents); Africa (Wolpe, Lazarus, Perls); USA (Rogers, May, Ellis, Beck, Skinner, Watson). Most have lived and worked in the USA, where they have had the freedom to develop what they thought to be relevant and appropriate approaches to psychotherapy. Secondly, their *expressed personal belief systems* have reflected aspects of their *spirituality* which is sometimes evident in their theories. For example, Freud emphasised the importance of the role of our instincts, while Rogers emphasised the intrinsic goodness of humankind. Baars and Frankl professed the meaningfulness of suffering, and the importance of a relationship with their creator, God. Moreno repeatedly and systematically played the role of God, and saw himself in the same role as Jesus. Yalom has a more scientific positivist approach, with a strong belief in science, and is skeptical about any non-material or spiritual understandings of life.

The integration of the spiritual dimension in psychotherapy has gained increasing recognition in practice. Blatner (2005) has the following to say about transpersonal psychology: “*Moreno's work recognized the relevance of religious imagery and belief and worked with it from the outset. Moreno himself felt that all his methods derived from a literally mystical sense of the immanence of the Divine in the creative process, however it may be manifested in the Cosmos (Moreno, 1971). In practical terms, psychodramatic*

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methods may be useful in exploring client's experiences with religion, their sense of meaning and purpose, and their source of solace" (p. 408).

Jung (Jaffé in Jung, 1963) wrote the following to a young clergyman in 1952, nine years before his death: "*I find that all my thoughts circle around God like the planets around the sun, and are as irresistibly attracted by Him. I would feel it to be the grossest sin if I were to oppose any resistance to this force*" (p. 13).

In an entertaining, witty, and uncompromising manner, Ellis (1997) gave the following honest self disclosure about himself at the third conference on *The Evolution of Psychotherapy* in Las Vegas USA, during his paper presentation entitled *The Evolution of Albert Ellis and Rational Emotive Behavior Therapy*: "*It took me almost my first two decades to talk myself out of that crap of being ingratiating. I was born and reared to be shy and scared. Throughout my childhood and teens I had a real social phobia. I viewed public speaking as a fate worse than public masturbation. I opened my physically large mouth only among a group of my close friends. I avoided telling jokes for fear of flubbing the punch lines. I said nothing—literally nothing—about my feelings for the pretty young girls that I kept falling madly—in fact, obsessively-compulsively—in love with. As for approaching any of the young women I immoderately lusted after from the age of twelve onward, forget it! I heard and saw nothing but 'evil' and 'horrible' rejection—so I kept my big trap shut. In spite of my deranged passion for everything in skirts, up to the age of twenty my dating amounted to zero. Yes, nothing, nil, none, zero*" (pp. 69-70).
One of Brooks-Harris and Gavetti's (2005a, 2008) fourteen multicultural strategies, spells out that the integration of the client's spiritual awareness, or faith development allows for the patient's holistic growth. The spiritual and transpersonal aspects of psychotherapy will again be addressed in Chapter 6 (Sections 6.4 and 6.12), and in Chapter 9.

A brief diversion of the role of the psychologist as *therapist*, *scientist*, and *researcher* will be discussed in the following two sections, before the supervision aspect of psychotherapy is looked at.

4.11 The Psychologist as Therapist and Scientist

Linking to and referring to the time that Rollo May awaited the outcome of the future of clinical psychology in 1955-6, which he refers to as the "dangerous years" (refer to Section 4.5 above), brings to mind what happened seven years earlier, known as the famous *Boulder Conference* which took place in August, 1949 in the state of Colorado USA, from which the *Scientist-Practitioner Model* of clinical education emanated, and has since shaped the profession of clinical psychology (Freedheim, 2003). Also referred to as, *The Colorado Conference on Graduate Education in Clinical Psychology*, the Boulder Conference included more than 70 psychologists, which was psychology's first attempt to look at the social value of applied psychology. The conference was experienced as an encouraging development for those within the American Psychological Association (APA), whose interests were in the applied use of psychology. It was however not appealing to those who were complacent with the traditional pursuit of scientific psychology, wherein clinical and practical applications were only incidental to research itself (Freedheim, 2003). Stricker and Cummings (2003) state that "*An attempt would be made to train clinical psychologists as scientists and as practitioners, not in professional schools but in traditional academic institutions*" (p. 802). The following three recommendations of the Boulder Conference deserve special attention:

- Each department would have to establish the standard of clinical competence expected at each stage of training, and would have to maintain a continuous evaluation of students in regard to these standards;
- Teachers of clinical psychology would have to maintain their clinical skills by continuing some clinical practice. "*The press to 'publish or perish' did not support the continuation of clinical practice among many university faculty members, who found themselves preaching what they did not practice*" (pp.803-4)
- The internship was *not* to be a *repair shop* in which the failures of the academic centre were taken care of. The university would have to adequately carry out its function of providing the necessary training in skills subjects so that the student could take the fullest advantage of what the internship was set up primarily to provide, namely, material in which to use the skills (Raimy, in Stricker &

> Cummings (2003). "*The failure of the university to emphasise the necessary training led to dissatisfaction among psychologists working in the internship sites as well as among the graduate students. It was left up to the professional schools to take these recommendations seriously*" (p. 804).

The Boulder model served its purpose, but it also had its limitations as the only pattern of training for clinical psychologists. The boulder model was the major source of influence for over 25 years in the training of clinical psychology. During the 1950's there was much development within the boundaries developed by the Boulder Conference. For example in1950, there were 35 accredited programs, although none could be described as professional in nature. However during the same decade, "*…the clinical psychology program in the Department of Psychology at Adelphi University was accredited, and it can be seen as the forerunner of the professional school movement*" (Stricker & Cummings, 2003, p. 804).

4.12 Research and Psychotherapy

In line with the brief diversion of the Boulder model as scientist-practitioner in the previous section, a brief comment on research is also relevant at this stage of the discussion.

Sanford (1987) explains that: "*Until 1940, objective research studies in any way related to psychotherapy were practically nonexistent-perhaps there was a handful*" (p. 196). From 1940 to 1950 workers in client-centered orientations conducted and published more than 40 research studies with another 20 underway at the same time. There was a surge of significant research projects carried out, painstakingly designed, and reported. In the words of Carl Rogers "*…each one is described in sufficient detail so that any competent worker can verify the findings*" (Sanford, 1987, p. 196).

The importance of empirical research in psychotherapy has received greater recognition in recent years which is a positive development both for increasing all knowledge of the

psychotherapeutic process and the effectiveness of its procedures (Bergin & Garfield, 1994; Lambert, 2004).

Although qualitative and quantitative methods have had a place in psychotherapy for a long time, there has been a traditional division between the ‘tender-minded’ (qualitative) approach and the more ‘exact’ (quantitative) approach that dominates the field, and in the studies that have been reviewed. However there is still something to be said for the rich and more meaningful accounts of therapeutic change by the authors who advocate qualitative methods who, “ *…assert that the majority of practitioners are turned off and uninfluenced by psychotherapy research because it does not capture the essential phenomena that the clinician perceives*” (Bergin & Garfield, 1994, p. 14).

Regarding research done on group psychotherapy, Lambert (2004) gives several illustrations of controlled research with *homogeneous, time limited* groups in the USA, and *inpatient diagnostically heterogeneous* groups in Europe, which have been published in Northern American and European journals over the past decade. There are significant differences in the manner which groups are structured and function on the two continents. For example publications show that the typical North American group is time limited (10 to 12 sessions) and of homogeneous composition, whereas groups conducted abroad [Europe] are long term (sometimes six months to a year or more) and are composed of diagnostically heterogeneous patients. However long-term groups are a core part in the clinical practice in North America but are underrepresented in the empirical literature.

In the Weskoppies context, the *homogeneous, time limited* groups, as well as the *inpatient diagnostically heterogeneous long term* groups, have been used, depending on my and the intern-psychologist’s assessment of the needs of the patients, the ward, and the hospital. For example group themes may focus on conflict management, anger management, communication skills, love, the good things in the hospital, relapse prevention, HIV AIDS, or dagga abuse.

4.13 Theoretical Perspectives in Training and Supervision

Explicit guidelines for the training of psychotherapists, has a relatively brief history. Research on training for psychotherapy has an even briefer history. Like many other fields of study, nineteenth-century psychiatry, followed the pattern of "… *'master' and students*" (Matarazzo & Garner, 2003, p. 850). At the beginning of the 1980's Hess (1980) together with more than thirty contributors, published a collection of original contributions, in an attempt to charter and define the regions and processes of teaching and learning psychotherapy skills, and in the development of human qualities that psychotherapists should possess.

Nevertheless, tracing the golden thread in the research carried out in psychotherapy education, training, and supervision, the emphasis clearly falls on the *supervision* aspect (Gold, 2006; Hess, 1980; Ladany, Friedlander, & Nelson, 2005; Snyders, 1985; Watson, 1997). While education focuses more on theoretical aspects, supervision focuses on the practical aspects of psychotherapy. Supervision involves talking about, or demonstrating (live) one's work with another. What a given therapist should do with a given patient at a given point in time cannot be predicted beforehand. It is in the *context of supervision* that the seemingly infinite number of variables can be addressed. The variables include all patient variables, therapist variables, and context variables.

The practical supervision and training of intern-psychologists is traditionally implemented in many ways. Watson, (1997, pp. 329-330) for example lists 21 major forms of supervising trainees. The following five methods have been used at Weskoppies and Dr. George Mukhari (Garankuwa) Hospitals over the past16 years:

- Presenting a written case study for supervision.
- Presenting a written case study and an audio cassette for supervision.
- Presenting a written case study and a video cassette for supervision.
- Group supervision.
- The supervisor sitting in on a live psychotherapy session.

The following contributions, in summary form, made by Snyders (1985), Watson (1997), Ladany et al. (2005), and Gold, (2006) illustrate how key aspects of supervision have been emphasised and refined, to include the present day influences encompassing the multicultural dimensions of psychotherapy and supervision.

4.13.1 Snyders's Contribution

In a study carried out in South Africa which clearly has an ecosystemic ring to it, Snyders (1985) emphasizes the importance of the *supervisory relationship*, in terms of supervisor and student variables, as well as contextual variables, developmental perspectives, and positive and negative supervisory contexts. On the basis of the results of Snyders's (1985) study, a *model of supervision* was designed, based on linking the five stages identified during supervision, namely, the *client system*, the *therapeutic system*, the *supervisory system*, the *observing system*, and the *political system*, to all aspects in the supervisory relationship. The task of the supervisor during these various stages is to demonstrate that an understanding of the *process* involved becomes more important than mere knowledge of the specific methods involved. Snyders (1985) aptly refers to Montgomery's (1978) caution that it "*…has been baffling - and a bit disconcerting – to learn a skill, and then use it in a consistently inappropriate manner at the wrong time, under the wrong circumstances, and for the wrong reasons*" (p. 28).

Snyders (1985) adds that this view is not only applicable to therapist-client interactions, but certainly also encompasses trainer-trainee relationships as well. He acknowledges that there are many ways of supervising trainee psychotherapists. The main message contained in the Snyders model (1985) is that supervision should be a context for various orders of learning by students and their supervisors, whereby art and technique should be blended so that supervision does not just become a sterile mechanical process.

Referring to the key ingredients of psychotherapy in the South African context, Mauer (1979) has illustrated how the therapeutic skills of psychotherapists while undergoing

their training, may reflect the high or low levels of *therapeutic empathy*, *warmth*, and *genuineness* of their trainers.

4.13.2 Watkins's Contribution

In his descriptions of supervision in fourteen different therapeutic modalities, Watkins (1997) highlights the following important aspects of why psychotherapy *supervision* plays such an important and key role in psychotherapy training:

- Supervision provides *feedback;*
- Supervision provides *guidance;*
- *Alternative views and perspectives* are obtained;
- It *stimulates* curiosity;
- It contributes to *therapist identity*;
- Support is afforded (a *secure base* is established).

"*Psychotherapy supervision is important because, among other possibilities, it provides supervisees with feedback about their performance; offers them guidance about what to do in times of confusion and need; allows them the opportunity to get alternative views and perspectives about patient dynamics, interventions, and course of treatment; stimulates or enhances curiosity about patients and the treatment experience; contributes to the forming of a therapist 'identity'; and serves as a 'secure base' for supervisees, letting them know that they are not alone in their learning about and performing of psychotherapy*" (p. 3)(words underlined are my own).

Furthermore psychotherapy supervision serves a critical *quality control* function, ensuring that:

- Patients are provided with acceptable care;
- Therapists do no harm;
- Therapists possess sufficient skills to function as 'therapists';
- Those who lack such skills are not allowed to continue without some form of remediation (Watkins, 1997). In South Africa the requirement of the CPD point

system (Continued Professional Development), would ensure this type of remediation.

4.13.3 Ladany, Friedlander, and Nelson's Contribution

While the above two contributions emphasise the nature of the supervisory relationship, Ladany et al. (2005) propose and emphasise the following *multicultural* therapeutic competencies that supervisees and supervisors need to acquire. Because this thesis focuses on the multicultural dimensions of treatment and training more attention will be given to the aspects offered by this supervision model.

Ladany et al. (2005) states that in order to acquire *multicultural therapeutic* competencies *supervisees'* need to acquire the following:

- Self awareness;
- General knowledge about multicultural issues;
- Multicultural psychotherapy self-efficacy;
- Understanding of unique client variables;
- Effective working alliance;
- Multicultural psychotherapy skills.

At the same time the *multicultural therapeutic* competencies and skills that *supervisors'* need to acquire and demonstrate to supervisees, are the following:

- Supervisor-focused personal development;
- Supervisee-focused personal development;
- Conceptualization (of all multicultural issues);
- Skills/interventions (that are appropriate and effective to unique multicultural situations);
- Process;
- Outcome/evaluation.

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As far as the *supervisor* is concerned, a key factor in any therapist's individual potential to become multiculturally competent is her/his own *identity* because multicultural identities in the supervisory dyad are said to influence both supervision and psychotherapy outcomes. Becoming aware of how one's interactions shape the multicultural identities that develop in therapy and in supervision needs to be recognized and worked on continuously.

For example in the USA, *socially oppressed groups* include:

- Women;
- People of color;
- Gay men/lesbians/bisexuals/trans-gendered individuals;
- People with disabilities;
- Working class individuals;
- Non-Christians.

On the other hand *socially privileged groups* include:

- Men;
- Whites;
- European Americans;
- Physically-abled people;
- Middle- and upper-class individuals;
- Christians.

In this framework, an individual can belong to both socially oppressed and socially privileged groups when more than one demographic factor is considered. For example, a gay, disabled White, Jewish. Middle-class male who has AIDS (Ladany et al., 2005). In the South African context an individual belonging to both socially oppressed and socially privileged groups when more than one demographic factor is considered may be illustrated as follows: A working class, pro-life Asian, Christian, requesting a same sex union.

4.13.4 Gold's Contribution

Gold (2006) uses the term of 'pretransference' to describe a patient's feelings towards a therapist of a different ethnic or racial background even before any therapy has commenced. "*This refers to a set of feelings, attitudes, prejudices, or identifications that a patient may have towards the therapist based on the therapist's ethnic origins*" (p. 70). In the same vein *age* and *gender* can also become 'pretransference' influences.

Referring once again to Carl Rogers and Rollo May's concern in the mid 1950's (Section 4.5 above), the question of *"Are we training technicians or professionals?"* is a continual reminder of how the process of the trainer-trainee supervision relationship should be developed. Also Truax and Carkhuff's (1977) caution of, "*Experience is not synonymous with maturity*" (p. 354) should be kept in mind. Most therapists become experienced, but few will truly mature as therapists or counsellors. Maturity implies a continued perfection of one's abilities to facilitate constructive change in the client who seeks help. Traux and Carkhuff (1977) point out that it is necessary to keep an open mind, and an attitude of *conservative experimentation*, meaning "*…a willingness to try other approaches and techniques that seem potentially helpful when the current approach seems ineffective at a given time with a given client*" (p. 355).

For psychotherapy treatment, training, and supervision in the 1940's and 50's, *psychodrama stages* were necessary implements in psychiatric departments in hospitals and psychology faculties throughout the USA (Marineau, 1989). Today a one-way mirror, audio cassette recorders, and video equipment are accepted as being standard and necessary items in Universities and training hospitals.

4.14 <u>In Vivo (Live) Supervision</u>

The practical supervision and training of intern-psychologists is traditionally implemented in many ways as discussed in the above section. The following five

methods have been used at Westfort, Weskoppies, and Dr. George Mukhari (Garankuwa) Hospitals over the past 16 years:

- Bringing a written case study for supervision;
- Bringing a written case study and an audio cassette for supervision;
- Bringing a written case study and a video cassette for supervision;
- Group supervision;
- The supervisor sitting in on a live psychotherapy session (In-Vivo or Live supervision) with or without an audio cassette recorder (Watkins, 1997).

Live psychotherapy supervision has been the major method employed by me over the past sixteen years. The advantages far outweigh the disadvantages. The major disadvantage is the initial stage-fright or performance anxiety that the intern-psychologist may experience. The big advantage is that it saves time, and when needed, the supervisor may assist as a co-therapist. Immediate feedback and discussion of all aspects of the case can be dealt with while still fresh in the minds of supervisor and intern-psychologist alike. For interns, it is not a popular method of supervision, but has been found to be the most effective way of practically dealing with the many unpredictable and challenging aspects that occur in the psychotherapeutic relationship. For example interns soon realize that *reflection of feelings* is not necessarily *empathy*. Reflection of feeling is a mechanical and learned response on the part of the therapist, but it can be done in such a way that it does not convey a warm and genuine understanding of what the patient is experiencing. This and similar aspects can be discussed and rectified in the feedback period after the session. Also, the intern soon realises that strategies and techniques may not be effective if the foundation of the relationship of trust is lacking.

For State Patients psychotherapy is aimed at achieving:

- General optimal functioning;
- Tailored rehabilitation on bio-psycho-social levels;
- Preparation for leave of absence (LOA);
- Identifying and clarifying aspects that may lead to relapse prevention;
- Preparation for conditional discharge leading up to eventual discharge;

- Social skills training (acknowledging greetings, e.g. good morning);
- Committed family support;
- Compliance to adequate medication;
- The integrating of all information gained from ward rounds, clinical assessments, psychometric assessments, and all available collateral information.

The following snapshot of a live psychotherapy supervision session (CAP/92-CAP/ 08, 1992-2008; Hospital Diaries, 1992-2008), between an intern psychologist (**Th.**) and a patient (**Pt.**) in a semi-closed ward illustrates an ecosystemic perspective of assessing and interpreting the interaction between therapist and patient. This is the third session between the intern and the patient.

Th. "So today Vusi, like I asked you last week, Mr Brown my supervisor is sitting in with us. Is it OK?" (*The therapist creates context*).
Pt. "Yes it's alright" (*Acceptance and a complementary relationship start*).
Th. "So where do I find you today?" (*Probes for the presenting problem*).
Pt. "Letta you know what the doctors do? They don't talk to you. They look at your file and your medication card and just continue with the medicine. I'm stuck, I'm trapped. Please explain to the doctors? Can you do that for me?" (*Manoeuvring for support and understanding in a blaming, and helpless manner*).
Th. "So you're feeling trapped in this ward and you feel that the doctors aren't listening to you. Is that right? Um…" (*Reflection of feeling, and attempting to gain clarity about patient's present mood*).
Pt. "Yes you know Letta I don't know why they keep me here. I am not sick, and I don't even need pills. They say I absconded, but I didn't come back from my leave because I got a job and I didn't want to tell the person I was working for that I am a patient at Weskoppies. They look at you when you tell them you come from Weskoppies. This place is worse than a jail I will never get out. Look I am healthy I even got a job outside there" (*A symmetrical struggle starts*).
Th." I hear you Vusi, but let's take one thing at a time" (*Attempting to refocus*).
Pt. (*Sighs and throws up his hands*).

Th. "I can see you are frustrated. Now let us take one thing at a time" (*Reflection of feeling, and firmly attempting to refocus and establish structure once more*).

Pt. (*Turns to me and says*) "You see Mr. Brown this place is worse than a prison. At least in prison you know when you are going to get out, but here they say you have to get better first. You know me Mr. Brown. You remember that I worked in the Army before they brought me to this hospital" (*Patient creates distance between himself and the therapist, and manoeuvres for closeness with the supervisor*).

Supervisor. "Yes Vusi I have known you for a long time now, and I have seen how you have been getting healthy and better all the time" (*There are a range of responses that might be deemed to be positive, neutral, or negative. I choose this response to firstly acknowledge what he said, secondly to give feedback about his past improvement*).

Pt. "Yes and also the social worker. She doesn't come and see me. I'm telling you I am stuck Mr. Brown, I'm stuck" (*Further manoeuvring for assistance and also for control, dependency, and distraction from the issue at hand*).

Supervisor. "Vusi I agree that we deal with one issue at a time, like Letta says." (*I choose this response to focus back on the interaction between the patient and the therapist and to facilitate direction in the process by empowering the intern's initiative*).

Pt. "OK" (*A complementary relationship starts again*).

Th. "Vusi you have been on successful leave before and on your last leave there were problems. Now…"

Pt. "Yes." (*The complementary relationship continues*).

Th. "Now it seems that you have not had the opportunity to talk to the doctors and the social workers to explain your point of view. So you and the doctors are not talking about everything; the doctors want you to take your medication again; the social worker is still trying to contact the area social worker to get a feedback report. Now let you and I try and find out how you can get what you need to go to an open ward again, and then to go on leave again." (*Using active listening to link all available information to set a therapeutic goal for this and future sessions*).

Pt. "Yes psychologist Letta, but I don't need the pills. The pills make me feel stiff. When I feel good and I can get a job then I am not sick any more. I don't need the medicine. I am not sick; it is the hospital that makes me sick Letta" (*Manoeuvring for distance*).

Th. "Vusi that is one of the big issues that we have to deal with; the issue of taking your medication even if you feel better. I know that in the ward rounds, the doctors and the nurses explain to you how important the pills are, but when you go on leave then you don't think it's important any more" (*Creating context again, and confronting the issue of the importance of taking medication*).

Referring to the *psychotherapeutic aims* for State patients (see p. 113 above) the intern addressed issues relating to:

- Identifying and clarifying aspects that may lead to relapse prevention;
- Compliance to adequate medication;
- General optimal functioning;
- Tailored rehabilitation on bio-psycho-social levels.

The above transcript can equally be interpreted within a psychodynamic perspective, in which resistance, transference, projection, denial, regression, and fixation are evident.

4.14.1 Discussion after Live Supervision

The following aspects are discussed:

i) Relating to the beginning therapist's possible obstacles Corey (2005) outlines sixteen obstacles. The following four points are relevant to the above supervision session:

- Dealing with the therapists anxieties (In the above case one source of anxiety was the supervisor's physical presence);
- Dealing with the demands of the patient;
- Tolerating ambiguity in the session;
- Declining to give advice to the patient.

ii) The effect of the intern's verbal and non-verbal behaviours known as the *Greenspoon effect* (Stieper & Wiener, 1965) is discussed. The Greenspoon effect suggests that patients can be influenced, sometimes without their being aware of it, by subtle

behaviours of the therapist, like nodding and grunting. The therapist should be aware when s/he subtly reinforces certain kinds of verbalizations and behaviours by nods, grunts, uh-huhs, um-ums, and other minimal social responses.

iii) The physical characteristics and dimensions of the room, and the way in which the therapist uses her/his body to communicate with the patient are again brought to the intern's attention. In this case Egan's (1975) **SOLER** aspects of physical attending are again noted. **S**–face the patient SQUARELY. **O-**-adopt an OPEN posture. **L**—LEAN towards the other. **E**—keep good EYE contact. **R**—try to be at home or relatively RELAXED in this position.

iv) The possible impact of the therapist's skin colour, culture, language, gender, and the other *multicultural therapeutic* competencies that *supervisees'* need to acquire (Ladany et al., 2005) are also noted and considered (refer to Section 4.13.3 above).

v) The quality of the *supervisory relationship* (Snyders, 1985) is also considered whereby the *art* and the *technique* of the process need to be blended, so that supervision does not just become a sterile mechanical process (refer to Section 4.13.1 above, and Section 3.2 fourth bullet, of Chapter 3).

vi) The intern is then asked to compile her clinical impressions and hypothesis in the format of an Interactional Pattern Analysis, using the 16 IPA dimensions (discussed in Chapter 3 Section 3.8.2, and Section 4.8 above), in preparation for discussion at a future ward round in which the patient will be presented.

4.15 Towards an Effective Multicultural Therapeutic Community

It is impressive and reassuring to observe the voluminous publications on aspects relating to multicultural psychotherapy that have appeared in the literature and on the internet in the past five years. For example in their latest edition, Prochaska and Norcross, (2007, pp. 419-450) devote a whole chapter entitled *multicultural therapies* in which they sketch

three multicultural pioneers, namely Lillian Comas-Dias, a Hispanic American, Stanley Sue, an Asian American, and Beverly Green, an African American. All three multicultural pioneers have been instrumental in facilitating the ongoing development of multicultural psychotherapy over the past twenty years.

The diversity of client problems and of client populations is increasing in South Africa. Therefore psychotherapy integration must include cultural influences in the assessment and treatment process. Norcross Hedges and Prochaska (2002) contend that multiculturalism is a reality that cannot be ignored by practitioners if they hope to meet the needs of their diverse client groups, therefore, "*A major challenge for the field of psychotherapy will be to discover creative ways to integrate the values and worldviews of multiple cultures within the discourse of efficiency and evidence that currently dominate health care. Such integration would produce a healthier future for the field and for populations that turn to psychotherapy to help them develop healthier and more balanced approaches to life*" (p. 322).

4.16 Conclusion

Many mental health workers such as psychiatrists, psychiatric nurses, educational psychologists, social workers, pastors, and lay counsellors, may have acquired a cognitive understanding, read about, and even may have written exams on transference and counter-transference, but have not necessarily been expected to personally experience the impact and effects of transference and counter-transference under supervision. Nor have they necessary been evaluated and assessed thereon, or even discussed, dialogued and received honest feedback on transference and counter-transference under supervision during their training. *That which arrives to replace a real relationship* often arrives subtlety, suddenly, and unpredictably, and if not equipped to deal with the experience, can retard, block and damage the therapeutic process. In describing the theoretical linkage of treatment and supervision, I have demonstrated what I regard to be an ethnographic aliveness and originality, by weaving each theorist's

contribution with some of his personal details, as well as sharing some of my thoughts on how each theorist's views have influenced my training of students.

Imagine one particular day in 1956.

Rollo May is sitting in his 25th floor office overlooking New York, sweating out the 'dangerous years.' Carl Rogers is in Chicago, publishing vigorously. Burrhus Skinner at Harvard University, where he remained for the rest of his life is very active, is doing research and guiding one of the hundreds of his doctoral candidates, as well as completing one of his many books on which he had worked, on and off, for twenty years entitled Verbal Behavior, *published in the following year of 1957. Fritz Perls is firmly established in his New York practice and has recently coined the term Gestalt Therapy, but not yet accepted by the academic world. Jacob Moreno creates the 'International Journal of Sociometry and Sociatry.' Albert Ellis (1913-2007) is busy preparing his presentation of his first demonstration of his rational approach to therapy at the annual convention of the American Psychological Association to be held in the following year, 1957. Two years later in 1959, Ellis established the Institute for Rational-Emotive Therapy in New York City. Aaron Temkin Beck (1921-) has recently joined the Department of Psychiatry of the University of Pennsylvania and is busy with his pioneering research on the efficacy of cognitive therapy for depression. Maxwell Jones* (discussed in Chapter 5, Section 5.9) *in the UK is establishing and influencing others with his new idea of a therapeutic community. Irvin Yalom is to graduate as Doctor of Medicine at the end of 1956. Joseph Wolpe still in Johannesburg, is close to publishing his new book entitled* Pyschotherapy by Reciprocal Inhibition, *is also influencing and stimulating Arnold Lazarus who is busy with his PhD in clinical psychology at Wits University in Johannesburg. The staff of Weskoppies Hospital in Pretoria the largest psychiatric hospital in South Africa, have recently adjusted to their new Department of Psychiatry attached to the medical faculty of the University of Pretoria. The staff at Westfort Hospital also situated in Pretoria is taking care of leper patients. While all of these activities are taking place simultaneously in 1956 the abovementioned health*

professionals and psychotherapists are in all likelihood unaware of each others anguish, excitement, enthusiasm, hopes, and successes, not to mention the future outcome thereof.

Two years later in 1958, J B (John Broadus) Watson, famous for his experiment with 'little Albert' (Geldard, 1963), *also a past president of the American Psychological Association in 1915, burned all his unpublished works and died a short time later that same year* (Watson, 1999).

The next chapter will focus on the therapeutic activities of the professional culture-sharing group at Weskoppies Hospital, within the context of the hospital's multicultural community.

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CHAPTER FIVE

PROFESSIONAL CULTURE-SHARING IN THE HOSPITAL

5.1 Daily Hand-Over Meetings

"The patient was very psychotic, so we had to sedate her and put her in a closed ward," explains the reporting psychiatric registrar as she giggles and laughs, pausing while some other staff members smile and laugh with her. She then continues with the daily *hand-over* report in a soft monotone voice.

"The next patient is Zac Mabusa, a Medunsa patient who has burned down one of the semi-closed wards. The patient's diagnosis is schizoaffective or bipolar mood disorder—I'm not sure, because his file contains both diagnoses. So anyway we put him in seclusion and increased his medication."

"Why aren't the Medunsa doctors reporting their own patient?" asks the chairperson.

"I think they are busy with mid-year exam preparations," someone volunteers.

"So Garf what do you know about the patient?" the chairperson asks me.

"I don't know any details about Mr. Mabusa," I reply. "He has never been referred to us for psychotherapy, or assessment, and because he is in a non-forensic ward, he does not come to our regular group therapy sessions. The psychologists have never been invited to attend a ward round in his ward either, so I am sorry I can't fill you in with any more information."

"Well now we must charge him," interjects the Unit Manager (matron). "And report the matter to the Serious Events Committee," adds the CEO. "So that when Head Office asks what we have done, then at least we can say we have reported the matter to the police and to the Serious Events Committee."

"Yes!" agrees most of the staff members, "Patients must start being responsible for what they do. They must learn discipline. It is costing us a lot of money the way they are destroying our property."

"In the mean time, before the police take him away, see that he stays in seclusion," urges the CEO.

"So!" I think to myself, "The patient is being charged despite his diagnosis and despite the fact that he warned the two night staff personnel that he was going to burn down the ward

because he hadn't been allowed to make a telephone call for two weeks. Actually it was the same patient" I recall silently, "that smashed the computer in the open ward in which he was previously housed, and that's why he was sent to a semi-closed ward for so-called *behaviour modification*."

As I glance up at the notice board I once again see one of the many notices which regularly appear on the board. This particular notice occupying a large space has been on the board for more than a year which I entered in my Personal Diary in April 2004. It reads:

Genes *represent risk factors and not fated outcomes.*
We are **not** *doomed from the womb.*
Environmental factors *are of major importance.*

I think back to a previous *hand-over meeting* when the same chairperson reminded several psychiatric registrars at the meeting "Mustn't think that you can help all these patients with medication only. You need more than that!" And at a previous Medical Advisory meeting when the same chairperson intimated several times that medication is not always effective, and that all professions in the hospital must take responsibility for treatment and decision making, when the problem falls in the relevant therapist's field. "It must be a team effort," he boldly requested.

My attention again focuses on the here-and-now of this morning's *hand-over meeting*.
"Any more problems?" asks the chairperson.
Several nods from the other staff members, sitting round the large circular table, indicate that no more serious incidents took place during the previous day and night.
"Yes before we end, just one more thing," asks one of the attending Unit Managers (matrons). "Please ask all the doctors if they can transfer patients in the closed wards to open wards if possible, because there is a blockage, and we can't admit any more new patients, especially the State Patients."
"Sure"… "Okay"... "We'll see what we can do"… "We'll speak to our consultants", reply several voices simultaneously.

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I look on my watch and see that it is three minutes to eight (the *hand-over* meeting started at 07h45. I stand up and leave together with the two intern-psychologists and the chief social worker.

"How come?" asks Lesiba, the one intern-psychologist who has been working at Weskoppies Hospital for one month, "How come they never ask what the circumstances were, that led up to the patient's behaviour. Why do they think that only medication and a closed ward are going to help when the patient has actually been telling them that he is angry because his request to make a phone call to his family was refused? Also why wasn't he referred to a psychologist, seeing that he has been angry for so long?"

"I don't really know," I reply, "Whenever I ask a similar question at the *hand-over meetings* I am told that those issues should be discussed at the patient's next ward round. We cannot attend all the ward rounds in the hospital, so we never get to know the dynamics of all the cases presented at the daily hand-over meetings,"

"But why were there only two night staff on duty to look after the 139 patients in the ward?" asks Letta the other intern-psychologist.

"I guess it is because we are short staffed," I reply. "I wonder who is going to be held responsible," I continue, "for not checking the faulty sprinkler system in the newly built ward that Zac set alight, and, who in the multidisciplinary team is to be held responsible for not taking Zac's long standing threats seriously?"

Not all hand-over meetings deal with newsworthy aspects. Handover meetings typically deal with the previous 24 hours *admissions* and *problems in the wards*. The information given at these meetings are typically given in the following format: Patient name, age, diagnosis, Firm responsible, reason for discussion, ward assigned to, and other relevant details. Optimal medication is emphasised, and seclusion and/or transfer to a closed ward is prescribed when a patient misbehaves. Very little is ever discussed or explored about the circumstances surrounding the patient's behaviour, neither what had led up to the events precipitating his/her behaviour. Psychotherapy and other alternative interventions are very rarely recommended by hospital management.

As we drive back to Ward 59 where the Medunsa Firm have their offices, I spontaneously say to Lesiba and Letta "Well, things haven't changed much. It's much the same as how things in the USA were in the 1950's described by Vandenbos, Cummings & DeLeon (1992)

that: "*Psychiatrists sought to refer for psychological testing in the same manner they would order an X-ray or a laboratory test, and they resented any attempt by the reporting psychologist to go beyond merely describing a patient's test performance to diagnosis or even personality description"* (p. 83). Also Maxwell Jones' thoughts on the therapeutic community which Jones (1956) conceptualized over fifty years ago is still relevant today "...*how often is the wrong patient sent from an open to a closed ward in an attempt to resolve a tense ward situation? The fact is that we do not know and unless we attempt to analyze the disturbance we cannot find out. Such analysis will usually involve the whole ward community and may be difficult or impossible to carry out without free communication between patients and staff, and between the individual members in both groups*" (pp. 647-8).

My conversation with Lesiba and Letta, leads me to reflect on the 'Traps and the Tricks' that Thomas (1993) cautions, in that, researchers should not only see what serves their purpose, but to simply describe the context and let the reader evaluate and conclude on the basis of what has been shown (refer to Section 2.5.8 in Chapter 2).

Needless to say, in the following morning's local newspaper, the caption of less than 150 words reads as follows "*Weskoppies Hospital ward damaged in blaze*" (Nthite, 2004).

5.2 Ward 59 Culture-Sharing Group

Ward 59 is the only ward in the hospital in which all members of the multidisciplinary team (MDT) have offices under the same roof in which the patient's are lodged. As we enter the ward we hear the 25 patients singing before they are about to have their breakfast. Earlier at 07h40 before I left the ward for the hand-over meeting, the patients were doing exercises in the same venue. At the moment they are singing a popular hymn, *When the Fire Comes Down,* joined by two staff members. The other staff members are busy with breakfast arrangements and other administrative duties. Some patients approach Letta, Lesiba and I, and ask if they can wash the car for R10.00 to buy cigarettes. Informal contacts with patients during which their requests to wash our motor cars are made, are valuable opportunities to interact with them on a different level in a meaningful way.

Ward 59 is the fifth and final ward in the rehabilitation process, through which the patients rotate before they are finally discharged. Because Ward 59 functions so differently I will devote Chapter 6 to inquire more comprehensively into the mechanisms and the dynamics of the ward. I now want to move on and inquire into what happens in a ward round in Ward 59.

5.3 A Day in the Life of a Ward Round

A ward round normally takes on the following pattern:

"How many patients are we seeing today?" I ask, once all the multidisciplinary team (MDT) members are comfortably seated and at ease.
"Six!" replies the registrar, "four in this ward (Ward 59), and two in Ward 66. And then we have to discuss two possible transfers from the maximum security Ward 22, to be transferred to Ward 65, if Ward 65 has enough vacancies."
"Okay," says the consultant, "let's start. Who's first?"

The social worker interjects and says, "Jabulani Mabena and Paulus Niemeyer are back from their three months leave and we need to assess their progress, and if necessary extend their leave of absence for another three months. I have already interviewed them; their custodians are also here with them."

"Fine!" says the consultant, "but let's start with the in-patients first."
"The first patient is Andrew Conradie," continues the registrar, "we need to see him first because he has a job outside the hospital as a car-watch at the local supermarket. Remember he has been trying for a long time to get a job. Two weeks ago he got this job, but now he is requesting to come back after 5 p.m., because that's the busiest time in the car park, and that's when he can make the most money. He hasn't been on medication for the past two years; he still doesn't have a custodian, and his behaviour has been good in the ward according to the notes made during our last few ward rounds. The problem seems to be that the ward staff's routine will be disrupted if Andrew is allowed back at 5 p.m. Roll call is at 4 p.m., and medication and supper at 4.30 p.m.; and the night staff start their duties at 6 p.m."

"Yes it's definitely against hospital and ward protocol for patients to stay out after official working hours," responds the consultant. "Sister Jele what do you say?" addressing the chief professional nurse (CPN).

"It's true!" responds the CPN. "And it will also create problems in the ward for another reason, because other patients will say we are favouring Andrew because he is white. But we must also think of Andrew's future, because he sets a good example in the ward by showing that he is prepared to work and to look for his own custodian, which of course other patients don't appreciate or even realize."

The social worker comments that Andrew's parents still don't feel ready to commit themselves to be his permanent custodian.

The two intern-psychologists add that since Andrew does not internalize his aggression anymore like he did four years previously, by cutting his forearms and smoking dagga, and since he has learned to channel his energies in an acceptable and productive way - the results of three years of individual and group psychotherapy - we should assist Andrew to work towards his discharge as soon as possible. The consultant reminds us that his admission diagnosis was schizophrenia, and that his criminal charge was attempted murder.

"Sure," I add, " that was nine years ago when most of the (MDT) multidisciplinary team members were ready to send Andrew to Life Care where he was destined to stay for the rest of his life, being seen by a visiting psychiatrist and social worker maybe once every two months. Are we going to devalue the impact of our treatment and care on a label attached by other MDT members nine years ago? His leadership qualities have been beneficial to the ward *esprit de corps*. We can openly discuss with him, his attempts to manipulate other patients and staff members. He has played open cards with us for the last year, during which time he has clearly demonstrated his ability to change when we treat him as a trustworthy person. Besides, he has not been on any medication for two years and has in fact improved in his all-round behaviour. I doubt whether his admission diagnosis was correct. I say that because even at Westfort Hospital twelve years ago, the Medunsa team, at that stage had several cases where the so-called schizophrenia cleared up within one month of the patient's admission to Westfort, but their admission diagnoses remained, despite their rapid recovery."

"Yes I understand perfectly," replies the consultant. "According to The New Mental Health Act (2002), with the emphasis on deinstitutionalization and dehospitalization we need to work towards the patient's leave of absence (LOA) and discharge as realistically and as practically

as possible, but the problem is the Attorney General's office is so slow, and they want guarantees that the members of the community will be safe when we recommend a final discharge for our patients."

"Sure, " I interject, "Let's invite the two advocates from the attorney general's office to our ward rounds, like we have done in the past at Westfort Hospital, because they really do understand our problem and they also want to cut out the unnecessary red tape as much as possible. They are also overloaded with work, and I am sure they will welcome regular dialogue."

"Let's get back to Andrew's case," requests the occupational therapist. "You see when he did come to OT, he was a good influence on the other patients, but we didn't have enough stimulating tasks to occupy him with, so that's why he started looked for an outside job; and also Andrew now earns much more money than he would have in our flower assembly section."

After much discussion Andrew does *not* get permission to stay outside the hospital grounds after 5 p.m. Two MDT members argue that Andrew needs to be back in the ward by 4 pm in time for roll call, when medication is administered to the other patients, and to be ready for supper at 4.30 p.m., one and a half hours before the night staff arrive for duty.

One year later, during a ward round on 02 October 2006, Andrew notified the MDT that he had received employment as a security guard at a panel-beating garage two blocks from the hospital, with a salary of R500.00 per week.

Eight weeks later, during a ward round on 27 November 2006, Andrew's request for a transfer to the halfway house in Weskoppies Hospital called Tshepong House (Place of Hope) was refused. The reason being that one member in the committee that dealt with the applications for Tsepong remembered Andrew's past behaviour of several years ago, and convinced the other committee members that Andrew was not a suitable candidate for the halfway house privileges. Members of our MDT were furious. We felt that Andrew's progress in the past two years was not acknowledged; that our combined therapeutic efforts were devalued and invalidated by a committee who did not even consult us in their decision making. We agreed to make a written request to the Superintendent and CEO of Weskoppies Hospital to intervene on our behalf. Andrew also had his plans.

One and a half weeks later on 07 December 2006 Andrew's new employer attended the ward round and requested permission for Andrew to keep watch over the garage during December and over the Christmas and New Year period. Permission for outside accommodation was granted. Andrew was elated and shook hands with all MDT members as he left for his temporary newfound freedom and independence.

On 10 January 2007 Andrew's employer reported that he was greatly satisfied with Andrew's work over the Christmas and New Year period. He also made a written request that Andrew's leave be extended because he had arranged an apprenticeship, and was also willing to be Andrew's custodian. The employer was informed that the matter would be discussed at the next MDT ward round when all MDT members were back from their leave.

During the ward-round it is arranged that Johannes Jagers obtains new spectacles. An urgent dentist appointment is arranged for George Sebeka who has requested such an appointment several times previously. And so we continue with the ward round until approximately 12h00.

In daily ward rounds with Male State Patients, aspects discussed include the following, which will be discussed under, and within, relevant headings throughout the presentation of this thesis:

- Compliance to Medication;
- Ward behaviour;
- Readiness for leave and discharge;
- Family Support;
- Dagga Use and Abuse, sometimes used as a way of dealing with the hospital system;
- Absconding;
- Relapse and Relapse Prevention;
- Group Therapy and Occupational Therapy participation;
- The rationale for the privileges allocated in the Open and Closed Wards;
- The Attorney General's Office;
- Institutionalization and the New Mental Health Care Act;
- Staff shortages.

5.4 Male State Patients

The majority of the work done by the Medunsa team has to do with the rehabilitation of male State Patients who have been officially charged for an alleged crime and have been found to be mentally ill, so they have *not* been convicted by the courts. *Crimes* include: murder, attempted murder, rape, attempted rape, sodomy, indecent assault, assault with the intent to do grievous bodily harm, malicious damage to property, housebreaking, theft, armed robbery, hijacking, fraud, kidnapping, and possession of dagga. *Clinical diagnoses* include, schizophrenia, schizoaffective disorder, bipolar mood disorder, substance induced psychosis, major depression, mental retardation, and the range of personality disorders.

Just before our lunch break at 12h40 Lesiba and Letta ask if they can discuss issues surrounding the patients that they are seeing for psychotherapy, and whom they want to present for live supervision later in the week. Each taking a cup of coffee we walk to my office. We have time to discuss the following three issues, namely, compliance to medication, family support and dagga use and abuse.

5.5 Compliance to Medication

It goes with saying that appropriate medication is the important first stage intervention to stabilize the patient's clinical condition, once s/he is admitted to the hospital. Thereafter, optimal and regularly monitored medication greatly assists the patient to cooperate and to benefit from the expertise of other MDT members. Sometimes the side effects of the medication are mistaken for relapse or for the patient's pathology. During psychotherapy this aspect needs to be investigated. Also, of course, the patient may be secretly using dagga which just complicates the clinical picture as well as the whole process of psychotherapy. However, if the medication is working well, then one of the therapeutic goals is to motivate the patient to realize the importance of taking his medication, especially while on leave of absence.

As I share the following quotation with the interns I also ask them to keep Thomas'(1993) 'Traps 4 and 5" in mind, namely, not to over generalize facts, opinions, and conclusions, and

to keep a balanced outlook on all aspects of patient care and related research (refer to Section 2.5.8 in Chapter 2).

Vandenbos, et al. (1992) state that: "*The role of psychoactive drugs in mental health treatment has been a recurring topic of professional debate since such drugs were introduced in the late 1950s. Biologically oriented psychiatrists have heralded such drugs as psychiatry's one effective tool. Psychodynamic psychotherapists from all disciplines have expressed doubts about the real long-term value of such psychoactive pharmacological agents, and some have argued that such drugs actually interfere with the process of psychotherapy*" (p. 94).

5.6 Family Support

In Mngomas' (2001) in-depth qualitative study at Weskoppies Hospital which focused on the factors contributing towards relapse as perceived by three patients, all three rated *family relationships* (mother, father, siblings, spouse) as a most prominent factor contributing to their relapse. Interestingly in August of the following year, a circular issued by Lazarus and Thom, (2002) of the Gauteng Department of Health reads as follows:

"*Too often patients are referred to Lifecare without much effort having been made to trace the family, or with very little information about the family, or, when there has been contact with family, their being left with the impression that placement is 'for life' and that any further involvement on their part is optional and voluntary.*

However, while referral to a Lifecare facility was once regarded as for life-long custodial placement, in the 21st century, with renewed emphasis on psychosocial rehabilitation and community care, this can no longer be the case. While longer-term placements may be appropriate for some patients, the goal remains rehabilitation and return to care in the community. In this regard, the family has a central role. However, acknowledging the associated burden of care, efforts are being made to expand the amount of community care available, (particularly day care), in order to support the family in caring for the patient…It is, therefore, essential that every effort is made, from the very first contact with the patient and family, to highlight the fact that hospital admission is not permanent and that families

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need to remain actively involved in treatment and decisions about placement or discharge" *(pp. 1-2).*

The role of the social worker becomes particularly crucial in tracing and communicating with the patient's family and community members. During psychotherapy the tensions and conflicts in the patient's family and community systems need to be explored, and with the help of the social worker to arrange to meet with the relevant family members if possible.

5.7 Dagga Use and Abuse

"But a big problem in the hospital," says Letta, "is the easy availability of dagga in all the wards, including the closed wards, and even in the maximum security ward, and I feel that my therapeutic efforts become undermined, because I'm unable to work in a dagga free environment."

"Yes," I reply, "dagga has been an ongoing problem for many years, and in many ways it is the patient's way of dealing with the hospital system. For some patients the first time that they were exposed to dagga was in the hospital. There are of course persistent smokers who just refuse to stop smoking dagga. Anyway, in April 2004, at the request of the hospital superintendent I submitted a report offering the following guidelines to curb dagga usage in the *total culture-sharing group* of the hospital:

Firstly, remembering Jones' (1968) insistence of *multiple leadership,* which means the distribution of authority and power to many people in the therapeutic team, I pointed out the necessity to distinguish between *ward-routine* and *therapeutic programmes*. *Ward-routine* refers to the adherence of general hospital rules and regulations, which have to necessarily be clear and inflexible, like meal and medication times, and sleeping time. The chief professional nurse would be the obvious person to exercise authority and take responsibility for ward-routine activities. On the other hand *therapeutic programmes* need to be initiated and led by the clinicians. Therapeutic programmes are initiated and guided by the combined decisions of the MDT members, and are flexible and tailored to the patient's personality and personal situation, based on the well established psychological, social, medical, and nursing principals of treatment and rehabilitation.

Secondly, a way in which dagga use may be minimized and eventually eliminated, is through *regular communication* between *all* hospital personnel as well as *all* patients, which may be achieved in the following two ways. Regular *group therapy* and *climate meetings* in *all* wards involving *all* patients, including at least a professional nurse, a social worker, an occupational therapist, a doctor, and a psychologist. The aim of the group interaction is to effectively work towards each patient's needs, and address the influences that play a part in the patient's optimal rehabilitation process. Regular *sensitivity* or (*T-group*) *training* (Rogers, 1970; Shaffer & Galinsky, 1974) or *group- analysis* (Bion, 1959; Foulkes, 1982; Hopper, 1984) for all members of the MDT to be made available, and to be facilitated by an appropriately trained facilitator. The aim of these groups is to work effectively for each team member's needs and welfare. Passive participation in therapeutic groups is not enough; hands-on personal exposure is necessary, so that members can become aware of themselves as other people see them (Jones, 1968).

An additional aim of *regular communication* between *all* hospital personnel is *to prevent burn-out* (Van der Walt, 2001) among staff members in the work situation. However these group interactions need to extend to include *all* personnel in the hospital to encourage free and open communication on all levels of the hospital's structure. Incidentally at Westfort Hospital in 1996, I co-facilitated in two such sensitivity/group-analysis groups, in which members of the MDT took part three times a week for a month, that is 12 one and a half hour sessions. It worked wonders. Management didn't like it; they said we were wasting the nurse's time when they could be attending to patients. We pointed out that it is the *quality* of time spent with patients that counts and not the quantity of time. We invited management to take part in our next group arrangement. They declined and cancelled any further "group therapy" for staff members."

As I reach for Jones' (1968) text book called *Beyond the Therapeutic Community*, I continue talking while I find the page that I am looking for.

"It again brings to mind what Maxwell Jones experienced almost forty years ago, in his attempt to focus the therapeutic community around the patient's needs and not the doctor's or any other hospital authority's frame of reference, when he wrote '*Perhaps the greatest difficulty in this type of training* [sensitivity or T-group training] *applies to the most senior levels of staff. Matrons, physician superintendents, and others have usually been trained in an era when experience in group work was almost unknown. For such senior staff personnel to*

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forego the protection of their rank presents difficulties. To have a senior staff member accept discussion and criticism of his performance in a clinical or administrative situation by other staff members, and even patients, is difficult without a training period'" (p. xx).

Letta quickly uses this opportunity to say what she has wanted to share all along.
"Maxwell Jones made that statement almost forty years ago," she says enthusiastically, "but even today the idea of group therapy is scary for most people, and I can understand why, because you make yourself vulnerable; and with an inexperienced or a psychopathic group facilitator people feel exploited, and rightly so, because you are really encouraged to say what you feel and think. But at the same time getting back to the hospital context, three nurses from different wards have asked me if we can't give them group therapy and training, because they are really frustrated about a lot of things and then they start neglecting their patients. They have to keep up a professional front but inside they are boiling."
"I know," I add, "I have also been asked several times over the years, and I have always encouraged the nurses to ask their matrons to obtain formal and official consent to conduct the groups during working hours, because that seemed to be the main problem; and also if it was requested that an outside facilitator was required, then I could arrange it. In fact, in February 2000, when I did formally arrange and offer, group therapy and training, by means of a written invitation, to all clinical departments in the hospital, I got an indifferent and uncommitted response. The two outside facilitators were both attached to the South African Group Analytic Association and had done such training for many years locally and abroad."

Lesiba looks at his watch and shows that time is almost up when he says, "Well I suppose that ties up with the dagga problem in the hospital, because there is no true communication between the different clinical departments and with management and administration. The patients get punished for using the dagga but the real culprits, whoever they are, and who bring the dagga into the hospital get away scott-free with the patient's money in their pockets."

"However," I reply while standing up, "a proposal has been formulated by previous intern psychologists on how to minimize the impact that dagga has on the morale of *all* the health workers in the hospital. Remember the proposal in this document is not meant to be the final word on resolving the dagga problem, but rather an invitation to all disciplines to enter into an ongoing dialogue to address the problem from each clinician's point of view. After all, the

dagga problem does create a lot of work, and often unnecessary work for all of us. While we are killing these fires we can't attain our therapeutic goals."

I suggest that Letta, Lesiba and I have a look at the proposal again and discuss it with the other team members at a future ward round. I give them each a copy of the proposal and ask them to make comments, suggestions and modifications where they think necessary, and have it ready for the ward round in two days time. The proposal which is addressed to the hospital management, and signed by each member of the Medunsa Firm MDT, reads as follows:

CREATION OF A REHABILITATION WARD OR SERVICE FOR PATIENTS WHO USE DAGGA

On behalf of the multidisciplinary team we would like to bring the following matter to your attention:
Over time, as the multidisciplinary team has evaluated patients, it has been clearly observed that a large number of patients appear to use dagga within Weskoppies Hospital. This creates numerous problems within the wards, which may be broadly outlined as follows:

- The use of dagga interferes with the efficacy of the medication that the patients are using.
- It makes it difficult for medical staff to obtain an accurate picture of the effects of the medication on individual patients.
- It thus makes prescribing the most effective dosage and type of medication more difficult.
- It also complicates the management of patients by the nursing staff, since it leads to behaviour changes that would include an increase in psychiatric symptoms.
- It could therefore contribute to patients relapsing and/or displaying behaviour that make it difficult to manage them.
- Patients who did not use dagga previously can also become addicted due to the proximity to habitual dagga users in the wards.

Based on the above information we thus strongly recommend that a ward or service be created where patients could be referred to if they should be found to be using dagga. We further recommend that rehabilitation facilities be made available within Ward 59, which would serve

as a drug free environment. Alternatively a therapeutic team with a rehabilitation focus could be established, that would provide services for patients from all wards in the hospital. Thereby a genuine therapeutic contribution may be made to the patient's total management. The current practice of referring these patients to the maximum security wards, in the guise of behavior modification, does not in general appear to be having a noticeable impact on their substance abuse behaviour.

We trust that you consider our concern and suggestion in a favourable light since we believe that our proposal will contribute to addressing the major problem currently present in Weskoppies Hospital.

Yours sincerely

Multidisciplinary Team (Medunsa Firm)

During our lunch break in the tea room, joined by the three new psychiatric registrars, the conversation turns to the topic of Weskoppies' reputation, efficacy, and historical background. I share in the discussion by telling the small group the relevant information that I know. Keeping in mind Wolcott's (in Creswell, 1998) challenge, that researchers should establish what a stranger would have to know in order to understand what is going on in the culture sharing group or…"*even more challenging still, what a stranger would have to know in order to be able to participate in a meaningful way*" (p. 60), if he or she wishes to, I describe the culture sharing group of Weskoppies Hospital (refer to Section 2.5.7 in Chapter 2).

5.8 The Hospital Setting

The physical and architectural setting of the culture-sharing group at Weskoppies Hospital had its beginnings just over a hundred years ago. Weskoppies Hospital was declared a national monument on Friday 31 July 1981. The *National Monuments Council* (1981) gives the following account:

"*Owing to a lack of proper facilities, until 1892 the mentally ill in the South African Republic were accommodated in prisons. In 1892, however the construction of a 'Krankzinnigengesticht' (lunatic asylum) was commenced on the site of the present Weskoppies Hospital*" (p. 1).

The original buildings which still exist have been altered and modernized. Indeed, the facades of the main buildings and the gardens of Weskoppies Hospital have been declared a South African Monument. From Krankzinnigengesticht the name was altered to Pretoria Krankzinnigengesticht / Pretoria Lunatic Asylum (after the Anglo Boer war in approximately 1902) , then to Pretoria Sielsiekte Hospitaal / Pretoria Mental Hospital in 1911, and finally the name Weskoppies Psychiatric Hospital was given in 1947 (Burrows, 1958; National Monuments Council, 1981).

In 1891 during the construction of the "gesticht" an administrative official and a 'College of Curators' with J. M. Wolmarans as chairman were appointed to administer the "gesticht". By 1892 the trustees formulated *'Sixty Articles'* which were clear, practical, and down to earth guidelines for employees of the 'gesticht'. For example one rule stipulated that the patients were not to be laughed at. The following three articles give an idea of the tone and spirit in which the Articles were formulated.

"Artikel 3. Never be amused by the patient's behaviour: as a rule, behave as if you don't notice it.
Artikel 4. Always remember that mental cases are not responsible for their actions: never use immoderate language or behave reprehensibly; control yourself at all times.
Article 6. For ill-treating or striking a patient, immediate dismissal"
(Burrows, 1958, p. 290).

The first patient was admitted on 27 January 1892. By 1898, the in-patient population had increased to138 (Burrows, 1958, p. 290).

The planting of numerous trees started in 1912, the work being mainly done by patients. In 1981, the year in which the hospital was declared a National Monument, the seven original buildings formed a beautiful architectural complex, set in the peaceful surroundings abounding in the trees planted since 1912.

By the 1920's the hospital had gained the reputation as a centre of innovation and research. By 1937 it had become the training hospital for the University of the Witwatersrand Medical Students, as well as a school for mental health nurses (Edgar & Sapire, 2000). In 1981 Weskoppies Hospital where pioneer work with regard to modern psychiatric treatment had been done, was regarded as the largest institution for psychiatric treatment in the Republic of South Africa, and the oldest in the Transvaal Province, which is now know as Gauteng Province. The hospital's history is to a large extent also the history of the development of psychiatric nursing care in South Africa (National Monuments Council, 1981).

In 2008, approximately 820 patients in Weskoppies Hospital are been looked after by two broad groups of helping professionals, namely the University of Pretoria Firm, and the Medunsa Firm. The Medunsa Firm currently known as the University of the Limpopo, Medunsa Campus Firm, was previously known as the Medical University of Southern Africa.

The medical faculty of the University of Pretoria , (also known as TUC's, or TUK's which in turn is an acronym for Transvaal University College) has been involved with treatment and training at Weskoppies Hospital since 1947, while its Department of Psychiatry was established in the early 1950's (W. Bodemer, personal communication, March 14, 2006). The Department of Psychology attached to the University of Pretoria was established in Weskoppies Hospital in 1962 (A. L. Coetzee, personal communication, March 13, 2006). Medunsa's Department of Clinical and Applied Psychology and Department of Psychiatry has been instrumental in the treatment and training aspects at Weskoppies Hospital since 21 July 1997.

As I leave Ward 59 to go to Medunsa to present a seminar to the MB ChB III Medical Students on the psychological aspects of death and dying, I reflect on the naming of the roads in Weskoppies Hospital. The main road that runs from the main gate to the two maximum security wards is called *Freud* Avenue, which is about one kilometre long. The other roads are named after other psychotherapists, (*Jung, Bleuler, Kraepelin*), former hospital staff members, (*Morake, Rasakane, Kogale, Ramakgopa, Mawasha*), the planets *Uranus*, and *Saturn* and two of its 47 moons (*Phoebe, Trojan*), and mineral or gem stones (*Tiger Eye*, *Agate, Gips-gypsum, Alabaster, Floor*). Ward 59 is in *Mawasha* Avenue, in the North Western corner of the hospital grounds, next to the Police Training College.

The section of the notice on the board during this morning's hand-over meeting namely, *environmental factors are of major importance* comes to mind. "Well," I think to myself, "at least we have the ideal physical setting to establish a therapeutic environment. I wonder how long it will take before *all* personnel at Weskoppies really start working together towards the same therapeutic and rehabilitation goals suggested by visionaries such as Foudraine, (1974) and Jones (1956, 1968)."

5.9 A Therapeutic Community

Several weeks later during one of the daily ward rounds the proposal of the CREATION OF A REHABILITATION WARD OR SERVICE FOR PATIENTS WHO USE DAGGA is discussed.

"Maybe our proposal of a rehabilitation ward or service is seen to be too futuristic and too different to how the rest of the hospital functions," says the social worker.

"Yes imagine the tension that it can create when staff rotate and have to adjust to, and focus on the real issues of rehabilitation and behaviour modification, not like how the rest of the hospital functions at the moment," adds the OT.

"You know almost fifty years ago Jones (1956, p. 650) stated that '*There is nothing particularly new in the concept of a therapeutic community. John Wesley had something like this in mind when he formed his* bands *some 200 years ago*'," I quickly add. "We are not suggesting a revolutionary utopia; it's just an attitude shift on our part, towards a practical and an achievable goal in our workplace, implemented in many other psychiatric settings as documented in the literature."

"Yes but let's be realistic about this place," adds the consultant. "I have been working here for many years now and I don't think you should try and transplant an idea that comes from an overseas country, and expect it to work here."

"Well," I respond promptly, "If you consider the work of Bodemer (1984) and Porten (1981) who both did their MD research here at Weskoppies, then it becomes very clear that a knowledge of culture, customs and language plays an important part in the correct diagnosis of the culturally different patient, especially in the diagnosis of depression, in which we have seen how dagga complicates the clinical picture. Naturally we do not neglect nor negate the importance of biochemical and genetic factors. Accurate diagnosis of course has therapeutic, ethical, and financial implications for the correct treatment and management of the patient.

Porten (1981) specifically emphasises the role of environmental factors in the causes of a person's psychotic breakdown. On the dedication page of his thesis, Porten (1981) states: *'This work is dedicated to future generations, who, hopefully, will eliminate what I see as the conditions and causes of mental illness.'* We are the future generation."

"Yes Weskoppies is an already established community. All we need is to work together to make it a *therapeutic* community in which *true healing and rehabilitation* takes place," adds the CPN.

And so continues the discussion on the whole aspect of creating a drug free culture of a therapeutic environment in which individuals can readjust, heal, and become well again, which has been a constant challenge to the helping professions for many decades. It is sometimes seen to be an ideal, an illusion, a waste of money that could be spent better on more profitable and less labour intensive projects.

Jones's (1956, 1968) concept of the therapeutic community is well documented in the literature which can be briefly summed up as follows:

- The overall aim is "…*to help patients by making the optimal use of the skills and potential of staff, patients, and their relatives*" (1968, p. 2)
- Patients are able to usefully participate in the treatment of other patients.
- It is important to realize that tensions among staff members affect the treatment of patients.
- It is necessary to enhance the therapeutic possibilities of patient's social interactions even when staff is not present.
- It requires a flexible revision in existing staff and patient roles and role relationships depending on the type of patient; the treatment goals; the previous training of staff; the type of freedom of action granted to MDT members; the cooperation of the non-clinical staff members; the culture of the wider community and; economic factors.
- In ward meetings (climate meetings) patient's feelings and attitudes towards staff need to be expressed.
- An open and free communication network between patients and staff needs to be established, which may mean a reorganization of the all health professional's timetables.

- Leadership with sensitivity to the needs of others, and adopting a flexible and multiple leadership approach, while preserving wholeness of the therapeutic community is needed.
- A forum is necessary in which staff is able to verbalize their own anxieties relating to hospital issues and issues in the wider community.
- Group psychotherapy is a start in this direction.

The culture and influence of the two current academic institutions, namely the University of Pretoria and the University of the Limpopo, Medunsa Campus, are indeed able to implement and nurture such a therapeutic culture in the hospital. The hospital has been functioning as a community for many decades already, and the therapeutically trained staff have already established an atmosphere of rehabilitation.

However the academic emphasis often replaces optimum service rendering. For example, over the Christmas periods, when there is a lessening in academic activities, patients are all of a sudden perceived to be fit and well enough to go on leave. Also, over the Easter period patients urgently request to attend religious services in their home community, and mostly their requests are granted. In reality many of the patients could have gone on leave beforehand, but were delayed due to some or other organizational (non-clinical) obstacle. For example, the influence of Medunsa merging with the University of the North, becoming the University of the Limpopo, created uncertainty, tension, resignations, and competition among some staff members which impacted on the staff's morale and motivation, as well as on the patient's well being.

5.10 How The New Mental Health Care Act is Conducive to a Therapeutic Community

The Preamble of The New Mental Health Care Act No 17 of 2002 reads as follows:-

"**Recognising** that health is a state of physical, mental and social well-being and that mental health services should be provided as part of primary, secondary and tertiary health services;

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Recognising that The Constitution of the Republic of South Africa, 1998 (Act No 108 of 1998), prohibits against unfair discrimination of people with mental and other disabilities;

Recognising that the person and the property of the person with mental disorders or mental disabilities, may at times require protection and that members of the public and their properties may similarly require protection from people with mental disorders or mental disabilities;

Recognising further that there is a need to promote the provision of mental health care services in a manner which promotes the maximum mental well-being of users of mental health care services and communities in which they reside;
BE IT THEREFORE ENACTED by the Parliament of the Republic of South Africa, as follows" (p. 2).

What follows is a 76 page document outlining all aspects relating to mental health in South Africa. The term *care users,* is used for voluntary and involuntary mentally ill people; the term *State Patients* is used for unconvicted State Patients and; the term *mentally ill prisoners* is used for convicted persons who are also mentally ill.

Chapter III of The New Mental Health Care Act (2002) entitled *Rights and Duties Relating to Mental Health care Users* emphasises the attitude of *respect and human dignity* which must be afforded to mental health care users (patients) by all staff. In my experience, by respecting the integrity and dignity of State Patients, care users, and mentally ill prisoners, already establishes a firm foundation for a stable therapeutic community. Each person whether patient, prisoner, or health worker, has value and worth. To identify and explore the person's psychopathology is absolutely necessary, but to get to know the whole person is just as important. Modlin's (1999) caution to clinicians comes to mind, namely that "*It is more important to know the patient who has the disease than to know the kind of disease from which the patient suffers*" (p. 11). On the staff's part, to implement an attitude of respect for each person's dignity and integrity is certainly an everyday challenge, but it is clearly observed that many staff members have already cultivated such attitudes. Many other aspects in The New Mental Health Care Act (2002) are conducive to establish a therapeutic culture, but by initially only focusing on the respect and dignity aspects already propagates a solid foundation on which Jones's (1956, 1968) concept of the therapeutic community can develop.

5.11 Restraining Factors Which Delay Patient's Discharge

Over the years, it has been frequently observed during ward rounds, group therapy, climate meetings, and all staff meetings, that the following obstacles are perceived to be the restraining factors which impede patient's therapeutic progress and eventual discharge:

- Stable patients are unable to return home because their family members or community members do not want them back in the family or community system. Family and community members may perceive the patient to be dangerous, emotionally disturbed, financially not viable, or just a plain nuisance (Venter, 2006b, 2006c).
- Weskoppies Hospital does not have specialised drug rehabilitation facilities. There is no programme and no drug free environment in which to treat patients who are sincere and serious about changing their lifestyles. Dagga is also easy obtainable in the hospital.
- The administrative process between the hospital and the attorney general's office is very slow.
- Staff shortages, overworked staff, and frequent staff turn-over, are aspects which slows down the overall process of patient flow (Green, 2006; Govender & Appel, 2006; Hosken, 2006a, 2006b, 2006c; Maughan, 2006; Mkhize, 2006; Otto, 2006b, 2007a). For example new registrars who first have to get to know the patient, keep the patient in a particular ward for an unnecessary length of time. Guess what happens? The patient becomes frustrated and angry, which is not perceived as a normal response which any normal person might express. Rather, the patient's behaviour is seen purely in a psychiatric context as a relapse, non-compliance, negativism, and aggressive behaviour. Then the inexperienced and overloaded and overworked registrar has a good reason to keep the "difficult" patient for even longer in the ward or the hospital for further observation and treatment.
- Patients use symptoms, to cope with certain dysfunctional aspects within the hospital system, in which they find themselves. For example not all patients have the freedom or skills to get in touch with, and express their feelings and attitudes towards insensitive staff members (Jones, 1956). Thus interventions, by psychologists, have to be made on a different (higher) therapeutic level to counteract the escalating (cyclical) pattern of the symptoms, often without the help of other staff members, who often do

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not have the time to join in discussions about how environmental and situational influences impact on patient's and staff's overall functioning and behaviour. Not even all psychologists have the training and the skills to understand and intervene effectively in order to counteract the patient's manoeuvres. On another level the cooperation of management is not always available, when for instance a managerial/structural intervention (like the ongoing dagga problem), could have prevented problems that manifest on a clinical level. For example when the names of patients and staff members, who are known dagga pushers are reported to management, then we are asked to prove it. Or when patients are physically or psychologically abused, then the staff member is transferred to another ward, without any treatment offered to the staff member.

5.12 Rehabilitation Programmes: Translating Words into Action

Every day words and concepts such as *psychotherapy*, *optimal medication*, *adjustment*, *healing*, *family stability*, and *patient compliance*, are used to convey growth and healing aspects in the domains of *body*, *mind*, and *spirit*. In the context of *society*, *family*, and *religion*, these same concepts refer to the patient's *growth*, *healing*, and *rehabilitation process*. The art and the challenge is how to translate these words into action. To rehabilitate means to *restore* a person to his/her level of effectiveness or normal life, by training, especially after imprisonment or illness (Thomson, 1995); in short *to enable again*, to enable the patient to utilize his/her resources and talents and to live, function, and grow as an optimally productive individual as possible.

In my experience psychotherapy *theory,* is the careful and concise attempt to cultivate concepts into becoming practical guidelines. In the context of the treatment of patients and of training of psychologists, Snyders (1985) reminds his readers that theories of psychotherapy are mere models of reality, and that the *application* of these theoretical models *generates specific processes* in all psychotherapeutic relationships. An understanding of the *process* involved in treatment and training becomes more important than mere knowledge of how the specific theoretical methods work. The challenge is to translate these theoretical concepts and guidelines into action.

In the rehabilitation of State Patients, the words and concepts used by MDT members often have different meanings for the different members of the team. Concepts such as *therapeutic interventions*, *behaviour modification*, and *therapeutic goals* also have different meanings for MDT members as a result of their previous training, personal experiences, and their general attitude towards healing and rehabilitation. The word rehabilitation itself has different meanings for clinical and administrative staff members in the hospital. In a positive sense, rehabilitation may be seen as working with a hospital population who are perceived and described as individuals who are stigmatized and unemployed, who are also classified as patients, and who are unfortunate individuals who have not learned to respect their own dignity and integrity, and who have consequently either robbed, hurt, or killed their victims. In a negative sense, but also commonly accepted as a more realistic term, these same people can be described simply as perpetrators, criminals, and recidivists.

To *know about* a person and *to know* the person are two different realities. To know the diagnostic features about a person and to know *all* the personality characteristics about the person as Modlin (1999) reminds his readers, are two completely different ways of describing and experiencing the person. In the many clinical and administrative meetings in the hospital setting, information *about* a patient is disclosed. In psychotherapy the patient is *known* on a deeper and more intimate level, depending of course on the relationship of trust established. As the patient graduates through the different ward systems, different aspects or emphases of the total rehabilitation process is focused on, and implemented, during each stage of the patient's rotation from Ward 22 (maximum security) through Wards 65 (semi-closed) and 66 (semi-open), eventually to Ward 59 (open ward).

5.12 Conclusion

The aspects referred to and discussed in this chapter, focus on the therapeutic activities of the professional culture-sharing group at Weskoppies Hospital, within the context of the hospital's multicultural community. As I reflect on the concepts of culture, healing, and psychotherapy, I call to mind how Gielen et al. (2004), describe culture to be that part of our ecology and environment that has been generated or created by ourselves. I also recall Corsini and Wedding's (2005) summary of psychotherapy and healing, as being our responsibility to *know ourselves* (through our cognitive faculties), to *love our neighbors* (as inspired by our

affections), and to *do good works* (through our behaviors), which was already known and implemented by several wise men and women many centuries ago.

To ensure a smooth flow in the reading of the above chapter I have not always overtly referred to Thomas's (1993) Traps and Tricks nor Hammersley's (1990) criteria in guiding this ethnographic inquiry of the aspects discussed and outlined in Chapter 2. For example in my description of the hand over meetings and the sections of the culture-sharing group of the hospital I have kept to my own original and creative understanding of ethnographic narrative.

In the next chapter the culture-sharing group of Ward 59 will be inquired into, and how the transition of the culture of Westfort Hospital evolved into the culture-sharing group of the Medunsa therapeutic team working at Weskoppies Hospital.

CHAPTER SIX

PROFESSIONAL CULTURE-SHARING IN WARD 59: AN OPEN WARD

6.1 Introduction

The physical structure of Ward 59 is situated in the South Western corner of the hospital grounds, built on an old hospital refuse dump. The characteristic spirit or ethos of Ward 59 has its roots in the tradition of the culture-sharing group of the ward systems in Westfort Hospital, developed since 1986. Several professional and auxiliary nurses, one social worker, two psychiatrists, three registrars, and I, were able to transplant the ethos of Westfort Hospital into the allocated Ward 59, when all the Medunsa patients were transferred to Weskoppies Hospital in July 1997. The essential difference between the two hospitals was that in practice, Weskoppies Hospital functioned according to the Eurocentric model, and Westfort Hospital (Medunsa Firm) adopted an Ecosystemic approach with many Afrocentric elements. The two approaches now had to blend. The differences in the two approaches often generated tension, suspicion, and open debate during hospital meetings, the morning hand-over meetings, ward rounds, and between patients and nurses who were now exposed to a different way of doing things. I may add that as word got round, patients preferred the Medunsa approach, because it was openly observed that the Medunsa patients were getting leave and going home much quicker than the other patients. The general policy of the Medunsa team was to get patients ready for leave as soon as was practically and ethically possible. The fact that the Medunsa Firm had group sessions on a weekly basis, afforded patients and staff an opportunity to explore and express their frustrations and expectations, which other patients in the hospital could not do on a regular basis. For example the culture in each ward (culture-sharing group) within Weskoppies Hospital had general but also distinct privileges attached to its ward-rules. Ward rules create structure and expectations for patients. In the

group sessions patients slowly, became aware of their rights as well as their responsibilities, which sometimes led to patients becoming assertive which some staff members could not relate to. Personal past experiences played a part in what patients and staff expected in their new environment. The past experiences of Westfort Hospital took many years to blend in with the new expectations of the Weskoppies Hospital way of doing things, both, on the part of patients and all MDT members.

6.2 The Ecosystemic Approach in Action: A Therapeutic Community in the Making

Many newcomers to Ward 59 ask: "How is Weskoppies Hospital different from Westfort Hospital?"

"I will try and explain as best I can," I reply, as I spontaneously recall some of the three and a half (3½) years I spent working at Westfort Hospital, from 01 January 1994 to 27 July 1997.

Keeping in mind Wolcott's (in Creswell, 1998) challenge, referred to in Chapter 2 Section 2. 5. 7 of this thesis, that researchers should establish what a stranger would have to know in order to understand what is going on in the chosen field of research or "... *more challenging still, what a stranger would have to know in order to be able to participate in a meaningful way*" (p. 60), the following background of Westfort Hospital attempts to meet such a requirement.

6.3 Westfort Hospital

Westfort Hospital lies at the foot of the Magaliesberg mountain range eleven kilometres west of Pretoria. Up until 1997 it was in a quiet farm-like setting. Presently it has a large housing community on its Southern side and a busy road on the Western side. Established in 1898, Westfort Hospital had been a leper colony since1898, and started accommodating mainly black psychiatric patients in 1978. In1986 Medunsa psychiatric patients were under the care of Dr. Patric Mokhuane, the only black psychiatrist

countrywide, who was employed in the service of the Department of National Health and Population Development (Singleton, 1986). Dr. Mokhuane's attitude and approach towards psychiatry and mental illness, as described by Singleton (1986), is given in my following translation from Afrikaans into English:

"*Each patient that I treat is like a mirror, in which time and again, I see and learn something about myself. A good psychiatrist is definitely not someone who is born with a silver spoon in his/her mouth. To be a good psychiatrist a person should personally have gone through stages of depression, stress, and tension, in order to develop empathy towards one's patients. Personal exposure and experience of one's own depression, stress, and tension, gives you the necessary strength to stand firm, when you are confronted with your patient's problems*" (p. 26).

Mokhuane (in Singleton, 1986) explained that psychological instability among Blacks had become more evident as a result of their moving away from their traditional community life. In their traditional community system, with the help of built-in support systems, individuals were helped during their preparation while in their transition from one life-stage to the next (for example the initiating of young boys). Today however, these transitions with their concomitant changes have a more drastic and critical impact on the individual, because the individual is not adequately equipped to deal with, and resolve issues during the transition process (Hosken, 2007d; Sapa, 2007; Seale, 2006; Venter, 2006e). This causes uncertainty, tension, and depression, and if not treated in time it could develop into a serious psychological problem. In his approach to the treatment of the patient, Dr. Mokhuane also took into account the patient's traditional beliefs. The traditional healer leads the patient to believe that he is sick because he had done *wrong things* and because his ancestors were angry with him. In other words he is exposed to sickness and bad luck because he has weakened himself through his wrongful actions. By rectifying these *things*, or by ceasing these *wrong* activities, the patient will again win the favour of his ancestors, and will thus (in that manner) be healed of his sickness. Dr. Mokhuane says that this was clearly the case of the psyche overwhelming the body's resources, and as a psychiatrist he used the good and positive aspects of the

patient's condition, and integrated it with the established Western treatment methods to obtain the best results for the patient (Singleton, 1986).

In 1991 in an article (Van Zyl, 1991), Dr. Louis Schulman a psychiatrist at Westfort Hospital explains the treatment programme in my following translation from Afrikaans to English:
"*The one part of the treatment programme consists of psychiatric treatment involving medication only. The other part consists of a rehabilitation programme. Through rehabilitation we attempt to prevent the patient from continuing his criminal career and to eliminate the sickness which caused his crime. With this programme the total person is evaluated. The team that carries out the evaluation consists of the psychiatrist, medical practitioner, clinical psychologist, occupational therapist, social worker, and the psychiatric nurse. After completion of the evaluation, the rehabilitation programme gets worked out according to the needs of the patient, and also prepares the patient for his future discharge*" (p. 27).

In order to achieve this therapeutic goal, Dr. Shulman explains that one method was to allow the patients to role-play about how to deal with future problem situations, if they occurred. Another method was to divide the patients into different treatment groups. During their stay at Westfort Hospital the patient started off in Group C with minimal privileges and was restricted to the ward. The ward areas were spacious areas of land, fenced off from the other fenced off wards scattered around the farm-like setting. Group B patients could go on leave while Group A patients enjoyed the entire patient privileges which included regular leave, occupational therapy, earning an income, and eventual discharge (Van Zyl, 1991).

While Dr. Mokhuane highlights the importance of accurate empathy and the patient's personal and communal belief system, and Dr. Shulman highlights the importance of all team members in the rehabilitation programme, both psychiatrists are referring to aspects within the ecosystemic approach (refer to Chapter 3, Section 3. 8) without actually saying so.

In 1989 the first full-time black clinical psychologist was seconded from Medunsa to Westfort Hospital (A. L .S. Moleko, personal communication, February 14, 2006). In January 1994 when I took over the clinical psychology responsibilities at Westfort Hospital, I found myself in a system that was very unfamiliar to me. I knew that I had to use my previous expertise to face the new challenge. The psychiatric, nursing, social worker, and occupational therapy departments, that were established, had been functioning for the past five years. It soon became evident that many staff members were dissatisfied with the total functioning of the hospital for various reasons. I focused on the patient's psychological needs and on the maintenance and building up of the MDT system. The administrative and management functions of the hospital were not always supportive of how our MDT members approached our clinical responsibilities. I nevertheless carried out my duties according to my ethical, clinical, and professional experience, but I also had my own ideas. I knew that I was possibly setting myself up for negative feedback by implementing my ideas, but I also knew that if I didn't try then how would I know if my ideas would work or not. Using the twelve years of experience gained in private practice I knew what could work in a system that was free of the rules and protocol which were made by Provincial, Hospital, and Ward authorities. But here I found myself in a system restricted by rules and regulations made by people who were not familiar with all the practical knowledge and implications of the day to day situations. I admit that rules and protocol are necessary as guidelines, but in a therapeutic setting flexibility was also needed. Negative feedback did come, in the form of non-cooperation from some members of administration and management. But management also did not have all the answers. Workers often went on strike. Keeping in mind that 1994 was the year that the elections were to take place which eventually led to The New South Africa, it was not always clear what the striker's true motives were. In any event there were many influences that played a part in how I was going to function and adjust in this new rehabilitation system that was also in transition within the broader context of South Africa's ongoing transformation.

Newspaper headlines are meant to catch the eye, but they also risk the imprinting of misinformation in the mind. In 1997 on June 24 the local newspaper headline which read:

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"Westfort to close after 100 years" with the subheading '*Medieval torture chamber' was a leper colony and a psychiatric hospital*, (Christoforakis, 1997, p. 12**)** was captivating enough to make you want to read on. A year earlier the same newspaper had a similar captivating headline which read: *"State of city hospitals slammed: Report on psychiatric institutions says Weskoppies is in decay, Westfort should close*" (Motale & Sapa, 1996, p. 1). The newspaper headlines were of course sensational and partly misleading, but it generated enough publicity, and room for speculation and uncertainty which led to rumours among staff members. As already indicated, I was working at Westfort Hospital at the time.

The following brief story illustrates one of the many disruptive events which had to be dealt with in the hospital, which also captured the public's attention. On Friday 20 January 1995 the superintendent and the matron were held captive by hospital workers, because many staff members were very dissatisfied with the functioning of Westfort Hospital. I was with the superintendent and the matron when they were held captive in the superintendent's office. The workers who initiated the strike said that they had nothing against me because I was helping the patients. I was free to move in and out of the office where the two were held captive. I could make outside phone calls to assist them. Of course it was neither the superintendent nor the matron's fault but they were convenient scapegoats. The strike continued until the following Friday during which time all patients were evacuated to Weskoppies Hospital until the week thereafter.

The following example illustrates one of the many projects that the MDT members initiated at the hospital. A network was established with the police and community clinic members in the township of Atteridgeville. Atteridgeville is a township across the road from the hospital, one kilometre as the bird flies, and four kilometres by road. It was easy for patients who absconded from the hospital to go to Attridgeville, to seek refuge, support, or entertainment. By working with the police and community clinic members in Atteridgeville, all Westfort and Atteridgeville members were able to freely communicate with each other, and to timeously prevent or eliminate any problems caused by the patient who had absconded. Also the network ensured speedy transfer of the patient back to the

hospital, eliminating unnecessary detainment in police custody. The network was efficient and effective. The Community Clinic in Middleburg Mpumalanga also became involved in the network, because many patients in the Mpumalanga area were hospitalised at Westfort Hospital. Regular fortnightly meetings took place at the Atteridgeville Police Station and Community Clinic, or at Westfort Hospital. This project is one of many examples in which frustrated MDT members had to negotiate with the hospital management and administration in our attempt to create a therapeutic community. Firstly, the hospital management stopped giving our team members the use of a hospital vehicle to attend the fortnightly meetings if the meetings were to take place in Atteridgeville. The reason given was that the budget didn't allow it. Consequently we used our private vehicles. Subsequently, we were told that the Attrigeville Project was in the geographic area of Pretoria, and that Medunsa personnel belonged to the geographic area of Garankuwa, and so we needed to arrange transport from Garankuwa Hospital 33 kilometres away. It was at that stage that all patients were being relocated to Weskoppies Hospital. Our last Attrigeville Project meeting was held at Weskoppies Hospital on 22 August 1997, after which the clinical and administrative merging aspects into Weskoppies Hospital became the new priority to deal with.

One way of describing my work experience at Westfort Hospital is that it was challenging, never dull, and it offered a goldmine of opportunities for psychotherapy. Many of Jones' (1956, 1968) ideas about a therapeutic community, which have been implemented in the running and functioning of Ward 59, were already initiated in Westfort Hospital during the period 1986 to 1997. The clinical setting in which clinical psychology and clinical psychiatry was developed at Westfort Hospital initiated the *esprit de corps* of the culture-sharing group which evolved into the functioning of Ward 59 at Weskoppies Hospital. Ward 59 in Weskoppies Hospital had now assumed the role, of what in Westfort Hospital (Ward 5), was referred to as the *pre-discharge* ward.

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6.4 Accommodating the Others' Spirituality

In the present context spirituality refers to how one's values, ideals, and beliefs are reflected in one's total lifestyle; to make sense out of one's interior subjective life; to connect to nature, the cosmos, and the creator. For some it relates to biological and material survival, while for others it relates to exploring and finding a fuller meaning and purpose of life. It is not necessary part of one's formal religion, ideology, or worldview, although it may be influenced and shaped by these belief systems. Spirituality may be found in silence or in busyness, in work or play, in music or noise, in meditation or prayer, in nature or the cosmos, in a relationship with our ancestors, or a relationship with the creator of our ancestors, in deep and meaningful experiences, or in ordinary, but meaningful experiences. Referring back to Corsini and Wedding's (1975, 2005, 2008) reminder of to *know thyself, love thy neighbor, and do good works*, (Section 3.3.3 of Chapter 3), is one way of respecting and accommodating the others' belief system and spirituality, which enhances the therapist's ability to sense the inner world of the client's subjective experience. Within the framework of Brooks-Harris and Gavetti's (2005a, 2008) fourteen multicultural strategies (discussed in Chapter 9 Section 9.4.2), the integration of the client's spiritual awareness, or faith development allows for the patient's holistic growth.

As indicated in Chapter 5, Section 5.2, Ward 59 is the only ward in Weskoppies Hospital in which the patients and health professionals are housed in the same building. Because of the close proximity in which patients, psychologists, social workers, nursing personnel and psychiatric registrars interact on a daily basis, interactions and observations occur within formal as well as informal contexts. The consultant and the occupational therapist are the only members of the multidisciplinary team who do not have permanent offices in Ward 59. Up until 2001 the consultant did occupy an office in the ward, but since then two part-time consultants visit the ward for three mornings a week.

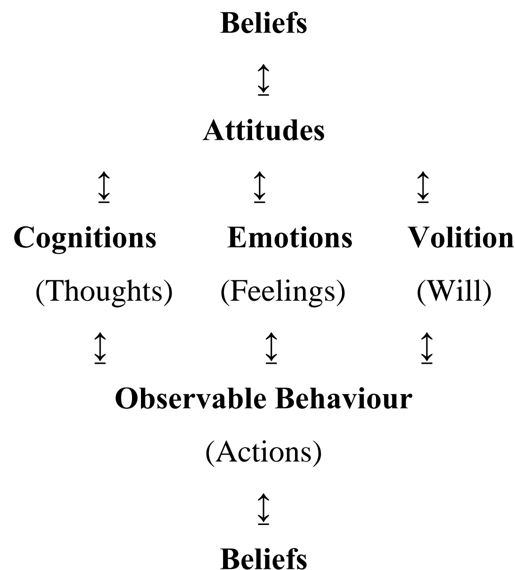
Linking to my observation noted in Chapter 4 Section 4.10, that a therapist's belief system is often reflected in the way that s/he works, I go on to say that a therapist's belief

system impacts on her/his spirituality or lack thereof, and is intimately interwoven with her/his cultural identity (Mishne, 2006; Mokhuane in Singleton, 1986). I need not go into the fascinating and complex discussion of *identity* at this stage of the discussion, but suffice to say that hospitalised patients have an identity and self concept of "I am sick; I can't help it; I need help." The mention of patients singing as a group before breakfast, noted in Section 5.2 of Chapter 5, is one example of how spiritual beliefs are linked to cultural identity. Patients are not forced to join in the early morning singing; in fact some patients do not join in. Staff members also do not discourage the singing. This is one example of how the spirituality of the other is respected. Even Jung (Jaffé in Jung 1963) who regarded himself primarily as a doctor and a psychiatrist "…*was well aware that the patients religious attitude plays a crucial role in the therapy of psychic illnes*s" (p. 12).

A psychotherapist's style or manner is reflected in what s/he believes works best in therapy as a result of her or his training and experience. Spirituality and traditional healing are closely linked in the sense that both aspects involve a person's beliefs (Moodley & Palmer, 2006). Similarly, cognitive behaviour therapy is also very closely linked to a person's belief system (Beck, 1976, 1995). Because our beliefs, attitudes, values, thoughts, will (volition), and actions, inextricably influence each other, it is not always easy to understand our true motives when making choices (Brown, in O.P.C.R, 2002). Psychotherapists in particular need to be attentive to this aspect when interacting with patients. Figure 6.1 overleaf, previously shown in Section 4. 1 of Chapter 4 illustrates once again how the above constructs are related to each other.

Referring to the interplay of all aspects of a person's functioning, (see *Ecosystemic Psychotherapy*, Chapter 3, Section 3. 8), a person's subjective experience may be described as, a pleasant or unpleasant thought, and/or feeling, and/or sensation (experienced by one of the five senses). Patients typically manifest their subjective experiences verbally, behaviourally, and symptomatically. Jung (1963) sheds light on this aspect; "*Outward circumstances are no substitute for inner experience. …I can understand myself only in the light of inner happenings*" (p.19).

Figure 6.1 **The Linkage between Core Constructs in Psychotherapy**



The spirituality of a psychotherapist means sharing and demonstrating her/his own beliefs, values, and sense of morality. It does not mean imposing one's beliefs but rather *exposing* what one stands for. Good therapy increases the therapists' as well as the patients' moral sensitivity, and builds character (Pipher, 1996). A therapeutic community implies cohesiveness or unity among all members, staff as well as patients. *Static* unity or *static* cohesiveness may be contrasted with *dynamic* unity or *dynamic* cohesiveness. *Dynamic unity* refers to the life giving and flexible growth of team members, in which all members experience emotional and spiritual sustenance and nourishment, drawing from each others' energy and creativity, contributing towards a culture of *heal*th *heal*ing. *Static unity* would imply the exact opposite. In the same way that one's management style or one's attitude impacts on the people in the workplace, so does the spirituality of the therapist permeate the ward atmosphere. Using my own spirituality to address the spiritual needs of the patients, I am able to offer (provide, facilitate, initiate) spiritual support and sustenance to the patients in the following ways:

- To allow patients free expression about their personal beliefs so that their personal and traditional belief systems become clearer and better understood.

- To encourage the patients to talk about how their personal beliefs can be either helpful or an obstacle along their road to recovery.
- To ask the hospital pastor to attend to the patient's needs by conducting prayer services, discussion meetings, or to distribute bibles and other literature to patients who request it, and allow patients to attend weekly church or mosque services either inside or outside the hospital.
- To ask the hospital pastor to arrange a visit by a priest or minister of religion from the patient's own religious denomination.
- To explain to patients that hospital policy does not appoint traditional healers as part of the hospital staff, when patients insist that their traditional beliefs need to be addressed by cultural methods of healing, in their request for a traditional healer to be part of the MDT.

The last point can be particularly challenging when patients insist that they are not respected or understood. I can give the following two examples in which I have dealt with such issues.

6.5 How "Acting Out" Rituals Compliments Treatment

The following two examples contain many elements of the gestalt therapy methods outlined in Chapter 4, Section 4.13.5. Both patients spontaneously put themselves in the *hot seat* so to speak. As soon as the patient decides to put himself in the *hot seat*, consciously or unconsciously, he is encouraged to stay in the *here-and-now* moment. Awareness of the *here-and-now* moment will allow the patient to become aware of the important *unfinished* situations in his life that has failed to emerge and become resolved, up until that moment. Prochaska and Norcross (2007) explain: "*Consciousness raising in Gestalt therapy is aimed at liberating people from maya, from the phony, fantasy level of existence*" (p. 175).

The first example relates to an incident in 1996. John Masemola, a Non-State Patient, was admitted to Westfort Hospital and diagnosed as bipolar mood disorder. John was a

former security guard at a local Casino. He had received appropriate and optimal medication in the hospital, but continued with his disruptive and bizarre behaviour by speaking incoherently in a loud tone of voice. He also broke a staff member's car window by throwing a rock against the closed window. John insisted that he needed to see his former traditional healer. In a therapeutic context, my colleague and I asked John how he thought his traditional healer would treat him. It was 15h00 on a Wednesday afternoon and John acted out his ritual in the following way. He collected plants, grass, sticks, old newspapers, and rags, brought it into the psychologist's tea room, and added these ingredients to a mixture of mud that he had prepared in a large dish. John chanted in an incoherent and hypnotic way, while he continued to stir and transfer his mixture from the basin into bottles and cans which he also collected. He also continually went in and out of the room transferring part of his mixture into the garden outside. John never spoke to us and we never asked any questions. By 17h00 he looked up at us and said he was finished with his ritual. The next day John was lucid, cooperative, humorous and compliant, and remained like that until his conditional discharge two weeks later. He was seen as an out-patient at Garankuwa hospital on a regular basis, to monitor his medication. He was now living in that area and had found a job. Twice, John found me on the Medunsa University campus. He was still functioning well when I last saw him informally in 2001. No doubt a combination of many influences, including medication, the acting out ritual, a relationship of respect and trust, and past therapeutic interventions played a part in John's recovery.

The second example relates to Justice Sefala at Weskoppies Hospital in 2002, a State Patient charged with malicious damage to his own property. Justice had absconded and had just returned to the hospital. His diagnosis was substance induced psychosis, and he had not taken any medication since he had absconded two months previously. He told the MDT that he had changed his religion from Christianity to Islam, and was also in training to become a Sangoma (traditional healer). He was wearing amulets around his neck, wrists and ankles, and carried sticks, grass and stones in order to practice his newly learned rituals. He responded to fellow-patient's ridicules by isolating himself, or by being verbally abusive towards his tormentors. My first intervention was to persuade

team members to transfer Justice from the closed ward that he was admitted into, and into our open Ward 59. I would take responsibility for his total treatment because I had seen him in therapy previously. I knew Justice from the Westfort Hospital days. Eventually he was transferred to Ward 59. My contract with Justice was that he was allowed to practice his rituals provided he did not hurt himself and other patients, and that he kept away from staff member's vehicles. (Justice had washed two staff member's motor cars but left them dirtier than before.) I also arranged to see him twice weekly for psychotherapy, which he accepted. He however refused to attend the weekly group therapy meetings, because other group members would confront or ridicule him. He brought his sticks, stones, and grass with him to the individual therapy sessions. Soon he decided to stop pursuing his interest in Sangoma training and resumed to make contact with his family again. Family members attended several ward rounds to discuss his way forward. Alcohol abuse during his leave of absence and his periods of absconding was a major influence in his relapses. Currently Justice is on his regular three monthly leave period. He has reverted back to Christianity, takes his medication and is a welcome member of his family again.

Appropriate clinical interventions with patients who display strong religious beliefs must be based on the therapist's ability to discern between, normal and pathological beliefs, and to evaluate the interplay between the patient's personal experiences, cultural, traditional, and home background (Mishne, 2006; Mokhuane, in Singleton, 1986; Moodley & Palmer, 2006). A reliable and practical way of ensuring whether the patient's belief system is pathological or not, is by establishing a relationship of trust with the patient, and by obtaining accurate collateral information,

To illustrate the role played by traditional healers, Bodemer's (1984) research sheds some light on the aspect. This study which extended over a three year period included a total of 11,030 black patients, of which 403 patients presented with a depressive syndrome. Only 31 of the 403 patients complied with the DSM III criteria for depression. Twenty six (26) of the 31 patients diagnosed with depression had *first visited a traditional healer* before their psychiatric consultation, compared to a group of 31 patients diagnosed as schizophrenic, in which 7 patients in the schizophrenic group visited a traditional healer

before their admission to Weskoppies Hospital. With reference to the 31 depressed patients, Bodemer (1984) states that, "*It was found that the cultural background of the patient played an integral part in the mode of clinical presentation of the depression and the customs of the people probably were responsible for the fact that fewer black people with depression presented themselves at a psychiatric hospital or a psychiatric outpatient clinic. The Black languages also pose a problem in that they do not have an accepted word for depressio*n" (p. vi).

The above two examples of John Masemola and Justice Sefala, echo what I came across in the literature several years later in Miller and Crabtree's (2005) recognizing of the "… *face and importance of spirituality in human life. Qualitative researchers also perceive that the therapeutic or healing process occurs not only in the clinical moments but also in everyday life between clinical events*" (p. 612).

6.6 An Example of "Prescribing the Symptom"

David Mahada was known for his ability to abscond from any open or closed ward in which he was admitted in Weskoppies Hospital. He also boldly announced that he would do so shortly before he absconded. David was also always successful in his absconding behaviour, with the result that he gained the reputation of "habitual absconder." With much reasoning and persuasion, the MDT members agreed to immediately transfer David to the open Ward 59 on his readmission to hospital after one of David's successful absconding episodes. Absconding was not David's real problem; his real problem was his home situation. As for the absconding behaviour, in David's case it was actually a problem that the hospital was creating for itself. David's absconding behaviour was a symptom of how he was reacting to his larger problem, which centered round the conditions at his home, and his dysfunctional relationship with his widowed mother, whom he mostly went to when he absconded, because he knew that she was to draw her pension on that day. On his admission to the open ward, David was told that the MDT members were not interested in his absconding behaviour, and that he could abscond if he wished (*prescribing the symptom*), but that the MDT were going to invite his mother to

the next ward round to focus on his home situation and the dysfunctional relationship with her. David's mother willingly came to two ward rounds over a period of one month without David attempting to leave the hospital. Issues were discussed and partly resolved, and conditions were set up as to what the MDT expected from David. David went on conditional leave for two weeks, then one month, then three months, over a period of almost two years without incident. One day he came back from leave smelling of cannabis, and admitted that he had not taken medication for a month, when a newly appointed registrar transferred him to a closed ward again. By then the MDT members had changed and new negotiations to implement the previous decision of transferring him back to Ward 59 was met with resistance. Once his condition was stabilised with medication and nutrition, David again announced his intention to abscond from the closed ward in the near future, which he again did successfully.

6.7 Open and Closed Wards

Open and closed wards are some of the physical structures which are certainly useful when used appropriately and therapeutically. The physical arrangements and the physical setting of hospitals, wards and consulting rooms either add to, or detract from establishing a therapeutic milieu, and in obtaining optimal care and treatment of clients and patients (Brammer & Shostrom, 1968; Foudraine, 1974). However Foudraine (1974) states that it is well and good to have open and closed wards, but what is equally imperative, is to have staff who are willing to cultivate open minds, and who are able to establish open communication with colleagues and with patients. Closed wards often have the effect of a narrow, constricted and closed way of thinking on patients and staff alike. As I have worked in these open and closed wards, I have often wondered and suggested how the physical arrangements can be used or redesigned to be more conducive to patients and staff alike. To work and live in these wards is an adjustment for both staff and patients. I don't have a clear answer as I grapple with this matter but I believe that well trained and motivated staff is just as important as all the physical barricades. When I have discussed my concern with co-workers, I have been told that fences, walls, and bars are absolutely essential in psychiatric hospitals, especially State

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hospitals, and that this is so the world over. Perhaps my ideas are somewhat idealistic and futuristic, but I also know that as medication has improved, so are some of the physical restraints that have been applied in the past, less frequently used today. As I reflect on these issues I recall what I had written and shared during live supervision with clinical interns, namely that "… *psychotherapy and rehabilitation, is a journey engaging in the day to day realities of patient's tasks and responsibilities. It is not a bundle of theoretical models and hospital protocols thrown on the patient*" (Personal Diary, 27 December, 2005).

I also call to mind how other psychotherapists (Foudraine,1974; Jones, 1956, 1968) have questioned similar issues, and have to a certain extent influenced other health professional's attitudes towards psychotherapy and mental health in general. Within the context of *open mind* and *open communication* the following three accounts shed some light on how Harry Stack Sullivan, Jacob Moreno, and Carl Rogers persisted in their attempts to "make things better", which eventually culminated in the sharing of their ideas in the larger systemic context of working toward, and helping humankind to work towards world peace.

Harry Stack Sullivan who throughout his working life struggled to include *the social* within his therapeutic formulations and to integrate what he had learned from his contacts with anthropologists and social scientists, especially those of the *Chicago school.* His *childhood experience* as *a victim of ethnic group prejudice and discrimination* also appeared to have sensitized him to the effects of *the political*. Not surprisingly, because his theory emphasises *interpersonal interaction* rather than intrapsychic structures. "*Sullivan is one of the least understood and least credited theoreticians in the history of psychotherapy. Although his thinking appears to have influenced or anticipated many current psychotherapies, he is rarely given the credit he deserves* "(Havens & Frank, 1971 in Cushman, 1992, pp. 45-46).

Cushman (1992) continues:

"*Sullivan is usually identified with the New York – Washington, DC group that began in the 1930s, comprised of Erich Fromm, Karen Horney, Frieda Fromm-Reichmann, Clara Thomson, and William Alanson White. However Sullivan began his unusual career in the 1920s, surprising the psychiatric world with an 80% success rate on a schizophrenic ward at Sheppard and Enoch Pratt Hospital in Towson, Maryland during the years 1923–1931 (Perry, 1982). Because he wrote so seldom (and so poorly), we have little information about those early years of his work. In his later years he wrote about the self and what he called the* ***self system*** *long before the self was fashionable in psychoanalytic circles. He was convinced that children develop a pattern of behavior, a personality, in order to prevent, avoid or assuage the anxiety of their parents. The self system, therefore, is more of a response to the interpersonal environment and less an inevitable product of conflicting internal psychic structures. His therapeutic technique focused on the interaction between the therapist (conceptualized as a* ***participant-observer****) and the patient within the therapy session. At the end of his life, appalled by the World War II and the atom bomb, he devoted himself to an expanded interpersonal realm: political activity related to world peace and nuclear disarmament*" (pp. 45-46).

Jacob Moreno's visited Russia in1959, at which time he was world famous for more than two decades. Marineau (1989) reports that while in Moscow, Moreno *"… suggested that for the advancement for peace, the Russian and American leaders, Khrushchev and Eisenhower, should reverse roles*" (p.147). Moreno was convinced that through role reversal world leaders would gain the necessary perspective that would bring about understanding and would increase the likelihood of peace. By leaders re-enacting social or political conflicts, would bring about a new social order. He also tried to intervene with the leaders of Russia and China (Mao Tse-tung), and during the Vietnam War he offered to help President Lyndon Johnson. Marineau, (1989) gives the following account "*Moreno wanted to build bridges between east and west. After his trip to the Soviet Union he wrote: 'We psychiatrists should be the first to open our arms wide and start on the road of international scientific cooperation. International scientific cooperation means the exchange of the best ideas and methods developed East or West, as much as*

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possible free from ideological bias and national persuasions, in the spirit of genuine mutual appreciation'" (pp.147-148).

Corey (2005) has the following to say about **Carl Rogers** referred to as a 'quiet revolutionary': "*During the last 15 years of his life, Rogers applied the person-centered approach to world peace by training policy makers, leaders, and groups in conflict. Perhaps his greatest passion was directed toward the reduction of interracial tensions and the effort to achieve world peace, for which he was nominated for the Nobel Peace Prize. ... He was not afraid to take a strong position and challenge the status quo throughout his professional career*" (p. 163). One example of Rogers's (1986) attempts to bring about interracial tension, took place while visiting South Africa in 1982, five years before his death in 1987.

The above three accounts are examples of visions that extend beyond the concept of a therapeutic milieu extending to a context of world peace.

6.8 Rehabilitation Programmes

Rehabilitation and preparation for discharge is done mainly during group therapy sessions, ward rounds, occupational therapy programmes, and routine ward activities, after which the patient's progress is discussed by all disciplines at the MDT meetings. In Ward 59 groups are not always attended by all patients. Although encouraged, patients are not forced to attend the weekly groups. Patients in open wards have the entire patient privileges available to them, which includes attending OT, free access to the Tuck shop, meeting girlfriends, requesting regular leave, and obtaining employment outside of the hospital grounds. Many patients have been attending the weekly group sessions through the rotation process from Wards 22 (maximum security) to 65 to 66 (semi-closed, and semi-open wards) before coming to Ward 59 (open ward). Despite irregular attendance there are times when group therapy and climate meetings in Ward 59 become very active and productive. For example before a Family Day programme, a soccer game, the Easter

and Christmas holidays, or attending the Pretoria Show every September, members show a keener interest in attending the groups.

In one of the group therapy meetings Frank Nkwe, who had now eventually been transferred to Ward 59 from Ward 66 (a semi-closed ward), wanted to share with the group members, how he was helped by being feeling understood, and for standing up for what he believed in. Frank told his story and encouraged the group members to persist in doing their best, even if they sometimes made mistakes.

The following report which I was asked to submit to the CEO of Weskoppies Hospital gives a broader perspective of what Frank was sharing with the group members that day.

Report: Mr Frank Nkwe

As requested by the nursing management I submit the following report surrounding Mr. Nkwe's written complaint to the S A Nursing Council.

1 Background

1.1 On September 05, 2003 during the weekly group therapy and climate meeting held with Ward 65 and 66 patients, Mr. Nkwe asked group members how to lodge a complaint about a staff member. The consensus of the group was that Mr. Nkwe write a letter expressing his concerns, and to bring the letter to the next group meeting to discus the content thereof; alternatively to ask for an interview with the Unit Matron.

1.2 Some time between the end of September and the beginning of October 2003 it appears that Mr. Nkwe wrote a letter, and on his own initiative asked Chief Professional Nurse (CPN) Tebogo Mosito to hand it to the Unit Matron. Apparently the letter never reached its destination.

1.3 To provide a context, it is appropriate to note that the official opening of Wards 65 and 66 took place on 27 September 2003. The many preparations for the opening day may have distracted Mr. Nkwe from bringing the letter back to the group members for further discussion.

1.4 On 05 December 2003 after the last group therapy session for the year, Mr Nkwe handed me a sealed letter with a stamp on it and asked me to ask the social worker, according to protocol, to post it for him. I posted the letter myself.

2 Interview with Mr. Nkwe on 19 May 2003

In order to provide a fuller context for this report I had an interview with Mr. Nkwe on 19 May 2004. The following relevant information was obtained.

2.1 Sometime in July/August 2003, Mr Nkwe said that he was not feeling well and did not want to eat his breakfast. According to Mr. Nkwe, CPN Mr Donald Tladi said, “You are giving us a problem if you do not eat”, and then hit Mr Nkwe in the face in the presence of other staff members and patients. The other staff members, who were present according to Mr. Nkwe, were CPN Ms Tebogo Mosito, Mr Palweni and Auxiliary Nurse Gerry Msibi.

2.2 Mr Nkwe explains that he respects and feels safe in the presence of Mr. Gerry Msibi (Auxiliary Nurse) and wanted to give the letter to Mr. Msibi, but following protocol and also acknowledging the seniority of CPN Ms, Tebogo Mosito he rather asked her to hand over the written complaint to management. This took place in September/October 2003.

2.3 Mr. Nkwe’s reason for writing the letter is indicated in his following remarks.

- “I wanted to see a matron to explain and report the matter. I felt helpless.”
- “We are expected to be good patients for the staff…to make yourself favourable and to agree with everything which they say and to be good in front of the staff.”
- “Nurses protect themselves when we (patients) want to complain about them. We are not treated like human beings. Most of us are afraid to stand up for our rights. We feel like we are nothing. We are also human beings. We want to be treated with dignity and respect. We are not useless. Although I am a mental patient we are equal.”
- “Anyone can become a patient, anyone even the staff can become affected. We feel lost. We want to be encouraged even when you are wearing hospital clothes and slippers. You are still a person and one day you will be discharged.”
- Some staff members say we won’t progress any more, there is no future for us and we are useless. The Sotho Word is Palile.”

- "I don't want Mr. Donald Tladi to loose his job. I want to stop them to put a hand to the patients. I want them to treat me with respect and dignity as the Health Professionals say."
- "In the past when I felt oppressed by the staff I used to relapse when I stood up for my rights, and then I smoked dagga."
- "Now I will face up to my problem. I don't fight; I am not aggressive to the nurses; I speak calmly.
- "I want to stop this thing of them oppressing us, not to continue any more. Lets attack the problem and not the person, like we learn in group therapy, and get a good thing out of it"
- "I saw that they didn't want to help me and I would be stuck in the situation so I decided to write the letter."

Clinical Impressions of Mr. Nkwe

I have known Mr. Nkwe since 1997 and have observed his behaviour and have interacted with him in formal psychotherapy, group psychotherapy, ward rounds, and in informal hospital situations. His functioning has steadily improved over the years.

- As indicated in the above verbatim statements, Mr. Nkwe has always been able to express his feelings and thoughts clearly.

- Over Easter 2004 Mr. Nkwe returned from a successful leave period, during which time he realized that he needs to get back to his community as soon as possible. In the past Mr. Nkwe often used to sabotage his opportunities to go on leave by either smoking dagga, drinking alcohol, fighting, or absconding on the actual day that his leave was due, or just before his leave was due.

- According to my clinical observations there have been no signs of psychosis or substance abuse in the past eight months. Regarding the 'hitting' incident Mr Nkwe states that there were no visible injuries sustained.

I trust that this report will be helpful to all concerned in resolving the issues surrounding Mr. Nkwe's complaint to the S. A. Nursing Council. If you require any additional information please let me know how I can assist.

Thank You
Sincerely
Mr. G A Brown
(Principal Clinical Psychologist)

After the above encounter, Frank became a 'model patient' and a good example to other patients. He became involved in all aspects of the rehabilitation programmes, to the extent that he obtained employment in the hospital Tuck shop, and started looking for outside employment, until he succumbed to dagga usage and was caught by a security guard who owed Frank money.

6.9 A Family Day in Ward 59

Taking Mngoma's (2001) and Lazarus and Thom's (2002) emphasis of family involvement seriously, once again a family day was planned for Saturday 19 October 2002. The previous family day took place on Saturday 25 November 2000. The objective was to start involving patient's family members on a more frequent basis to become instrumental in issues related to the patient's rehabilitation process. Approval from management was obtained to collect edible donations from various outside sources for 127 patients, 60 family members, and 20 staff members, totalling 207. It goes without saying that contacting all family members and requesting donations from outside sources was labour intensive and time consuming. The social worker contacted the family members, while the intern-psychologists and two professional nurses obtained donations in the form of foodstuffs from five sponsors. On the day only 25 family members arrived. A report was compiled and written feedback was given to management. The patient's family member's main concern was the inapproachability of staff members in the hospital. The family members needed a contact person with whom they could easily

make contact when they needed to. This aspect still remains a problem because day and night ward staff change, and so do psychiatric registrars.

6.10 Psychotherapeutic Approaches Used in the Open Ward

Because Ward 59 is an open ward, and patients are entitled to all hospital privileges, on the one hand there is generally more cooperation from the patients. On the other hand, because of their increased freedom in the hospital, patients often misuse their privileges. Diverse psychotherapeutic approaches and strategies are necessary to address and accommodate both types of behaviours. Using the **ecosystemic perspective** as a meta-perspective (as a foundation and umbrella perspective), all therapeutic approaches discussed in Chapter 4, namely, psychodynamic, behavioural, cognitive behavioural, person-centered, existential, gestalt, and group psychotherapies, become useful in the open ward. Some approaches are more useful than others depending on the context in which patients, hospital, and therapist circumstances become prominent.

As in all other wards, the **client–centered approach**, lays the foundation for establishing a relationship of trust with the patient. The therapist's ability to sense the inner world of the client's subjective experience is the essence of establishing the therapeutic alliance. Just this one aspect keeps the patient's hope and motivation alive as he rotates through the three wards, eventual to the open ward. The relationship between the therapist and the client, in combination with the inner and external resources of the client, is the foundation for effective therapy, especially in a multicultural context in which the use of the client's resources is central for therapeutic success. The **psychodynamic approach** is useful when the focus is on family dynamics, personal insight, and when the role of the patient's ego defences and other inner dynamics needs to be understood in how the patient deals with the stresses of the hospital and his home environmental. The formal and professional stance of the therapist may appeal to some clients who expect professional distance. In Ward 59 where the patient's expectations and needs are focused on leave and discharge, coping skills for dealing with everyday demands geared towards relapse prevention, becomes the focus of rehabilitation. For this reason **behavioural, cognitive behavioural,**

and **gestalt approaches,** are more effective. Family members and even some hospital staff do not value the patient's newly acquire assertive behaviour, consequently patients need to cope with resistance by these people. Clarifying how the patient's thoughts impact on his feelings, actions, and interpersonal relations, reinforces more adaptive cognitions, and encourages more accurate perceptions of the patient's future leave and discharge possibilities. Providing psycho-education, employing role-playing, and monitoring self behaviour, is used to create awareness in the patient's all round functioning. In **group psychotherapy**, issues of an **existential** nature are discussed, like the meaning of freedom and responsibility, the value of respecting others, and the value of life (Hospital Diaries, 1994-2008).

Sometimes the focus on the patient's *own responsibility* rather than the focus on social conditions become an **existential approach limitation** in working with culturally diverse populations. The following **limitations** of **gestalt therapy** are kept in mind in the multicultural contexts in all wards including Ward 59. Sometimes patients, who have been culturally conditioned to be emotionally reserved and withdrawn, might not see value in experiential techniques like the empty-chair, or role-reversal. Some patients have been 'put off' when focus on catharsis, or expression of their feelings are encouraged, especially in group settings. Patients frequently look for, and ask for, specific advice to solve practical problems, and don't see the value of 'playing games.' Initially patients are reluctant to show their feelings because they believe that to show their vulnerability is to expose their weakness (Corey, 2005).

6.11. Practical Issues in Training and Supervision

Ward 59 is the ward where all psychotherapeutic approaches can be implemented, because it is an open ward in which the patient can enjoy all hospital privileges, and is the final stage before going on leave and finally becoming discharged. There is also of course the temptation of misusing their freedom. Because all staff members are housed in the same building, informal contacts are made with patients every day. This requires that interns need to set boundaries, so as not to encourage a social interaction, yet maintaining

a healthy therapeutic milieu. Integrating information gained from ward rounds, clinical assessments, psychometric assessments, and all collateral information, is easier obtained in Ward 59 than in other wards, mainly because all members of staff meet in the ward every day, and because of the social workers availability and presence.

6.12 Towards an Effective Multicultural Therapeutic Community

It has been frequently observed that people with solid spiritual foundations (not necessarily religious), tend to be healthier, and recover better when their lives turn for the worse (Richards & Bergin, 2000; Sperry, 2001; Sperry & Shafranske, 2005; Weiner et al., 2005). As patients seek new and deeper meanings about themselves and their lives, more existential issues are raised in therapy, which consequently draws on the psychologist's spiritual and transpersonal repertoire of wisdom and knowledge. The involvement and cooperation of the hospital pastor is often helpful in this respect.

With regard to the Weskoppies Hospital system as described in this chapter and in Chapter 5, together with my personal experiences described in these chapters, and all theories of psychotherapy used as guidelines for training and treatment, the following aspects become evident. In order to develop a therapeutic culture appropriate to the task of treating patients in Weskoppies Hospital calls for cooperation from all members, clinical as well as administrative staff members. Psychotherapeutic interventions are more successful in institutions (hospitals) that have good leadership and are well managed. One example of achieving this level of expertise is by **not** imitating the principles and practices of general medicine, whereby the hierarchical structure serves the function of a medical hospital only. The function of a psychiatric hospital is different. The word *psychiatric*, which may include psychological and physical, already has a medical connotation, which minimizes the social, environmental, and non-medical aspects of treatment and rehabilitation.

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6.13 Conclusion

As I write this ethnographic inquiry, the patients in Ward 59, after 10 years, have been relocated to Ward 21, where patients and staff are once again housed in the same building. Ward 59 was built on an old refuse dump in the north western corner of the hospital. The ward foundation is sinking, and the walls are cracking. The location of Ward 21 is in the hub of activity in the hospital, next to the tuck shop. In Ward 21, across the passageway from the psychologist's offices, is a large spacious enclosure in which Electro Convulsive Therapy (ECT) is performed frequently. The ECT facilities will soon be moved to a newly built admissions ward. Many student nurses gather around the doctor and patient as the process of ECT is described and demonstrated. The ECT enclosure is a reminder of how prominent the bio-medical model has been in psychiatric practice. Roos et al. (2001) explain that ECT "*…was one of first biological psychiatric treatments to be used in the modern era. …Its exact mechanism of action remains unknown. … No other therapy has been demonstrated to be more effective than ECT in the treatment of major depressive disorders*" (p. 464). At the same time it is reassuring to know that Horn (2007) and McCallaghan (2007) agree that the decision to initiate a course of ECT, especially in the treatment of the acute manic episode subtype of bipolar disorders, should be considered under specialist supervision "*…as a life-saving measure in rare cases and in selected cases where medications are contraindicated*" (Horn, 2007, p. 453). According to my memory only two Medunsa Firm patients have been referred for ECT in the past 16 years. As I cast my mind back fourteen years ago, to Westfort Hospital where the ethos of Ward 59 emanated, I realize that currently The Medunsa Firm has been fully incorporated into the tradition of Weskoppies Hospital.

CHAPTER SEVEN

PROFESSIONAL CULTURE-SHARING IN WARDS 65 AND 66

7.1 Introduction

When the two new semi-closed wards, Wards 65 and 66 for State patients were officially opened on 27 August 2003, the master of ceremonies focused on the theme of the *therapeutic community* as conceptualized by Maxwell Jones (Jones, 1956, 1968).

In the following year at the 23rd Graduation ceremony of Medunsa on the 10th December 2004, the following large placards were placed next to the delegates sitting on the stage:

DEPARTMENT OF HEALTH
VISION

An accessible caring and high quality health system

MISSION

To improve health status through prevention and promotion of healthy life styles and to constantly improve the health care delivery system by focusing on access, equity, efficiency, quality and sustainability

It is apparent that the above *vision* and *mission* are very much in line with The New Mental Health Care Act No 17 of 2002, referred to in Chapter 5 of this thesis. I often ponder on how all these authorities can communicate and coordinate with each other, so that the workers on the ground, at grass-root level, can seriously implement this proposed *vision* and *mission*, and translate these words into action on a daily basis. Also in line

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with Jones's (1956, 1968) vision, and the concept of a culture of a therapeutic community, I often share with my co-workers and colleagues what we can do, to actualize and make the vision of *a therapeutic health care delivery system*, closer to the reality envisioned by The Department of Health. One way that we all agree on, is just to do our work properly under the circumstances and with the resources presently available to us.

7.2 Wards 65 and 66 (Semi-Closed and Semi-Open Wards)

In Wards 65 and 66, the Medunsa Firm has less autonomy in implementing ward, hospital, and National protocol, than in Ward 59 (open ward), because Wards 65 and 66 house patients allocated to several Firms, so for convenience sake one set of *rules* and ward protocol apply to all Firms. The protocols are meant to be *guidelines* to be used flexibly and creatively in a responsibly way, and implemented according to the combined consensus of the MDT members in line with the best interests of the patients. The challenge, for the nursing staff in Wards 65 and 66, is that they need to adjust to the way that the different Firms' interpret and implement the ward protocol.

"We have heard a lot about what happens in the closed wards," the two new MSc 1 students say who have joined their "buddy-interns" for their weekly orientation. Each MSc 1 student is allocated to an intern psychologist, and attends hospital activities for one morning a week, in order to familiarize themselves and prepare them for their own clinical internship in the following year. This arrangement is known as the "buddy-system."

"Fine let us go to Wards 65 and 66 and see how accurate your preconceived ideas are," I replied, as we started walking to the two wards which are about three hundred metres away from Ward 59.

As we approach the entrance to Ward 66, which is separated from the passage by steel gate bars, we are greeted by numerous patients who have just finished breakfast and waiting for the group to start. The ward seen through the intimidating bars is pleasant,

sunny and cheerful, leading into a reception area, with the nursing station to the left and the dining area to the right. As you look through the bars you immediately see the TV room ahead of you slightly to your left, with the open courtyard (partly covered), ahead slightly to your right. Some patients are outside in the open courtyard smoking after their breakfast. Someone calls the CPN (Chief Professional Nurse) who opens the gates for the psychologists to enter. Someone else rings the manual bell, and the word goes round that the group is to begin soon. Several patients crowd around the psychologists and an exchange of interactions takes place. Patient Skip Sithole avoids us because has been accused once again of peddling dagga in the ward and is waiting to go to the maximum security ward (Ward 22). Skip Sithole has committed several crimes while in hospital, including stealing one of the personnel's bicycle; stealing and selling curtains ripped through a window left open over a weekend by a staff member.

Anton De Bruyn and Paulus van den Berg were caught drinking the previous weekend and were sent from the open Ward 59 to the semi-closed Ward 65, until the next ward round was to take place. They both insisted that they were walking in the hospital grounds on the Saturday afternoon, which is a privilege to any open ward patient, and as they were hanging around the hospital club house, which was hired out for a wedding that Saturday, they were offered alcohol by one of the wedding guests. They gladly accepted. They never got drunk, but when they got back to Ward 59 the nurse on duty smelt the alcohol on them, and immediately arranged a transfer to a closed ward.

"Yes I said come to the group session this morning and you can tell us all about it if there is time, and if it fits into the chosen topic for today."

7.3 Group Therapy

Group therapy is one aspect of the total rehabilitation programme afforded to patients.
At Westfort Hospital we held our groups under the trees, even in the closed wards which were spacious areas of land, fenced off from the other fenced off wards scattered around the farm-like setting.

Groups typically consist of between ten to twenty five patients (the majority being patients belonging to the UP Firms), a senior psychologist, one or two intern-psychologists, one or two nurses or auxiliary nurses, and sometimes an occupational therapist and/or social worker and/or a psychiatric registrar.

Once the group members have brought enough chairs from the dining room area and have assembled in a circle, a group leader (chairperson) and a translator is chosen from all participants. It has become common practice for patients to lead the group with the psychologists to facilitate from a meta-position. By allowing patients to be group leaders is one way of improving their social skills and to remain focused on the chosen topic. It also gives the patients freedom to continue discussing group issues between group meetings. The group starts at 09h00 and finishes promptly at 10h00. Themes and decisions from the previous week's group are read and a topic is chosen for the day.

Today the chosen chairperson is a patient, Mark Murray. The translator is Patrick Mahlangu also a patient, who can speak four languages, namely English, Afrikaans, Sotho, and Zulu. The topic suggested is *life after discharge* and, *our ward behaviour*.

"First I think because we have new psychologists in the group, we must introduce ourselves. Each one must give his name, and tell us where you come from," says Mark the chairperson. Mark points to each group member in turn, and shows that we must go clockwise.

Mark then explains the group norms.

"If you want to talk raise your hand. Stick to the topic. If you want to go to the toilet ask me, the chairperson. Don't speak out of turn. Patrick, please translate so that everybody understands."

Patrick translates the group norms into Zulu and Sotho. Several hands are raised.

"Yes Moses."

"I want to say to Mr. Brown that we appreciate you psychologists coming to our groups but we talk about the same things over and over again. We are stuck in this hospital. The transfer to other wards takes too long and we will never get discharged. We want you to go to hospital management and tell them that we are not prisoners and that we are hospital patients, and when we are no longer sick then we must go home. We can't even go to the church service on Wednesdays and Sundays; we are not allowed to use the public phone, only if the staff comes with us, but they are always busy. No matter how hard we try to stick to the hospital rules we remain stuck here. No wonder some patients start smoking dagga and some abscond."

The intern psychologist says "Let's take one thing at a time."

"Okay," agrees the chairperson. "Remember everyone the theme is *life after discharge*, and *our behaviour in the ward*. So let's stick to the two topics."

Percy is again asked to translate what the last three speakers said. Casper is one of many whose hand is raised. "Yes Casper you can talk."

"Yes we stayed in Ward 22 for three months, some of us even longer, before we came here to Ward 65 and 66, and now we want to go to the open wards (Ward 59 in Medunsa's case) so please psychologists help us get out of this place, it is worse here than in Ward 22 in maximum security. At least in Ward 22 we didn't have to stay in such a closed place and we could practice soccer every day if we wanted to. We even had a vegetable garden there. Only some of us in this ward can go to OT, otherwise we have nothing to do in the ward." Patrick the translator translates.

"Yes Brian your turn to talk."

"I want to tell the new student psychologists (MSc 1 buddies) that I am a Coloured, and I want to talk about my children who are at home without a father. My sons are starting to smoke dagga and my daughter is becoming a prostitute…"

"You're out of topic," interrupts the chairperson. "We are talking about our ward behaviour, and life after discharge."

"Yes but…"

"Sorry you are disrupting the group meeting Brian," adds the Group Leader.

"It is part of my culture to smoke dagga. What right does the hospital have to interfere with my culture and my rights," interrupts Bheki without raising his hand.

"Hey Bekhi this is not a ward round, you can tell your doctor in your next ward round. Now let's keep to the topic," urges the group leader.

"Yes you are making this into a psychotic group again," shouts Brian with a big smile on his face. Everyone laughs. Smiling, Patrick translates the previous interactions.

The Group Leader, Mark Murray takes charge of the process. "I just want to say to all you guys, that it might take a long time, but everyone gets a chance to go on leave. I know, I have been on long leave twice, once for two years, and then I messed it up. I have only myself to blame for it. I started mixing with my old friends again; or rather they came looking for me and although I promised myself never to mix with them again, it was nice to see them again and to see what they were up to. Soon I was drinking and smoking dagga with them and then it led to cocaine. It was actually the girl friend I had then that tempted me with the hard stuff (cocaine). So I just want to tell you all that when you get your chance to go on leave, use it properly. And let me also tell you, it's not easy out there. If you can't keep to the ward protocol and the hospital rules then you won't respect the rules outside the hospital either. Yes Danny you want to say some thing."

"That's true what you say Mark. I know; me too. I have also been on leave plenty of times and it was difficult to find a job, and when people find out that you have been to Weskoppies then they don't want to talk to you any more. Then I think to myself 'well it's not so bad in Weskoppies you get clothes, and plenty of blankets, and food and even dagga and girls, and the nurses give you your treatment every day, so you can't forget to take your pills, and you won't easy relapse,' so I got into a fight and that's when they brought me back to the hospital."

After the translation Jonas Rama is given a chance to talk.

"Yes me too Mr, Brown. You know me, I'm HIV positive and when I go on leave I don't know how long I'm going to live so I enjoy myself, and I drink, and that's when my step-mother fights with my father, and then they bring me back to hospital before my leave ends."

After translating, the translator Patrick is given an opportunity to talk. "Last week when the social worker was here she said she would contact my mother. That's the only chance we have to contact our families, if the social worker phones for us. Otherwise we just have to wait and wait, that's why I absconded last month, just to contact my mother. I came back by myself the next day."

Prasanth quickly and assertively challenges Patrick by saying, "In my religion, you know the Hindu religion, we also have to look after our families, so that is why I once asked the psychologist, Willem, to help me contact my father, during one of our therapy sessions. He phoned my father in front of me and spoke to my father and explained what my problem was, and then let me speak to my father. And since then my father has visited me twice. My father phones me now but I think the staff doesn't always call me. The nurses say they can't find me. How can that be, I'm in the closed Ward, 65, and I can't go to OT like some of the patients in Ward 66 are allowed to. But now the problem is my brother who laid the charge of assault against me."

"Prasanth, you must wait for me to allow you talk," interrupts the chairperson, Mark.

Patient Gzinga walks into the group in a stiff posture, and insists that the members make room for him. Gzinga is an illegal refugee from Mozambique who had come into South Africa eight years previously. Gzinga had killed a child and eaten the liver for strength and protection; he speaks Portuguese and Shonga and is difficult to communicate with; he is also floridly psychotic. The CPN nurse gently ushers him out of the room.

Anton Du Bruyn and Paulus van den Berg's hands have been raised for some time now.

"Okay Anton and Paulus I suppose you want to talk about how you were caught drinking alcohol on Saturday," says he chairperson. "You know it's against hospital rules. Right, who wants to talk first?"

"Yes," replies Paulus, "We didn't mean to drink, and we didn't even try to hide it from the nurses. We know it's against hospital rules, but when we were standing outside the club house where the wedding was, these two *Oomies*, (uncles), came out and offered us a beer. They said 'come have *'n dop man*, (a drink man), no one will know,' and when we looked again they put a beer into our hands." All the group members laugh.

"Yes," continues Anton, "*'n Mens is 'n mens jy weet*, (a person is a person you know), so we drank the beer. I must admit it was nice. I haven't tasted beer since I was arrested seven years ago, and when people force you to drink what must you do?" Everybody laughs again.

"Order please, order please," interrupts the chairperson. After Patrick has finished translating, Paulus continues. "But you know we did make the mistake when they gave us the second beer. We should have walked away after the first beer, and now the nurses say we have relapsed. It's a chance we took, and you know it's so boring here over weekends."

"When we have the next ward round in this ward tomorrow you can tell the MDT what happened over the weekend, but right now, how can the group help you?" inquires the intern psychologist.

"Yes Moses," says the Group Leader indicating to him, "just let Patrick finish translating."

"You guys know that you have done wrong," says Moses, "I think you must tell the MDT that you are sorry that you did it, because even when you go on leave, and people offer you alcohol or dagga, then you must have the discipline to refuse. Look what happened to Mark, what he was telling us just now. He was on leave and now he is back in a closed ward. Not only that, but you give all the Medunsa patients a bad name, and then you spoil our chances to be transferred to an open ward or to go on leave. So c'mon

guys I think you must show them that you are really sorry, and you must take your punishment like a man."

"Please translate Patrick," as the chairperson holds his hand up, indicating to Moses, to stop.

"It wasn't only us," says Anton, "There were also three TUK's patients, but they never went back to their ward until much later, they went to the tuck shop to get some peppermints and to visit their girl friends in the women's ward."
"It doesn't matter what they did, Anton," interjects the chairperson. "Now let Patrick translate what Moses said."

Mark gives me a chance to say something.

"Thank you Mr. Murray, I just want to say to Moses that I heard you use the word *punishment*. Remember this is a hospital, and we don't punish, we give treatment. Punishment is not part of behaviour modification. So Moses what other word can you use to give a more accurate message to Anton and Paulus."
"Well what I want to say is that they must be prepared to loose some of their privileges, like coming to a closed ward, and wearing pyjamas for two weeks."

As Patrick translates several heads nod in agreement.

"We have ten minutes left," says the intern psychologist indicating on her watch.
The chairperson quickly responds by saying, "Okay those who haven't said anything today, I am going to go round the group and point to you, so we can hear what you have to say about everything we have spoken about today. Patrick please translate."

"When are we going to have a soccer game again?" asks Wonder Boy Maseko.
"I want a discharge," says Samson Mavembela.

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"I want to see a psychologist. Us Tukkies patients don't see psychologists like the Medunsa patients," Says Eric Masemola.

"Discharge."

"Nothing."

"Nothing."

"Yes discharge also."

"Transfer and discharge."

"The food is not enough, and it's not the food we are used to."

"We don't have money to buy our own cigarettes, that's why we fight in this ward. They give us condoms, but they don't give us cigarettes. What can we do with condoms in a closed ward? We don't do sodomy like some other patients do," says Jacob Zulu.

The Group Leader says, "Yes, but all these are out of topic, so maybe we can talk about it next week if you still want to. We have to end now."

The intern psychologist says, "How do you want to end the group today?"

"Let's first sing and then pray," replies Brian and starts singing *Kum-Ba-Ya*, as everyone joins in the singing.

As we walk to Ward 60, just down the corridor to see a non-forensic patient, the psychiatric registrar who joined the group for today says, "My word, now I've see how lucid Moses can be, he really thinks and speaks clearly. Not the way I've seen him speak in the ward rounds."

Themes extracted from the above group therapy session may be described as

- Transfer to open wards;
- Communication with family members;
- Difficulty in complying to ward protocol;
- Self discipline and hospital discipline.

Emotions manifested include frustration, anger, discrimination, hope, humour, helplessness, and immobilization

The **group process** refers to the way the group unfolds, evolves, adapts, or changes. In the above session the group alternated between, being disruptive and orderly, to being serious and playful, while being attentive to each others frustrations and needs.

The group **dynamics** refers to the way in which the energy generated was used, and may be described as being lively, energetic, with spontaneous communication, sometimes blaming and stormy, and sometimes solution focused, or evasive.

The **structure** of the group was a typical in-patient, male, diagnostically heterogeneous, hospital group, with no specific therapeutic goal decided upon.

While some of the issues were partly addressed, all aspects were written down and noted, and kept for future group sessions, depending on the priorities decided upon at future sessions.

Over the years, structured group therapy with selected participants has been conducted in all the wards in which Medunsa Firm patients' were housed. In some cases, personalized certificates designed and printed by the intern-psychologists were awarded to the patients.

Themes included the following:

- Relapse prevention;
- Overcoming dagga use and abuse;
- Ward behaviour;
- Handling strong feelings (love, anger, depression, craving, and withdrawal feelings);
- Life after discharge;
- Relationships with family, friends, peers, and loved ones (wife, children, girl friends);
- Music therapy;
- Finger painting;

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- Communication training;
- Problem solving;
- Stress management;
- Building self esteem and self respect.

Writers in the field of psychology, philosophy, and theology, writing on the subject of *self esteem* have attached both positive as well as negative connotations to the concept. In a negative light self esteem has been described as a selfish inflated ego, while the positive and more accepted understanding of self esteem, emphasises the notion of a person's capability, and being lovable; the notion of, "*I am capable and I am lovable. As a person I have value and I have worth*." Aspects of self esteem and self respect have invariably become sub-themes in most group discussions.

7.4 A Therapeutic Music Group

The following edited and modified version taken from process notes, reflections, in-vivo supervision, and a report describing the content and the process of *a therapeutic music group*, facilitated by two intern-psychologists (Haeck-Badenhorst & Field, 2005) reveals the essence of how the group was structured and how participants experienced the group interaction.

Context

Ward 65 represents a semi-closed ward in the Weskoppies Psychiatric Hospital. Patients are confined to the interior of a ward and find themselves in the middle of a system (between maximum security and an open ward). Their behavioural rehabilitation or lack thereof, can result in either their regression or progression in the psychiatric system; either retarding or advancing their aims of eventual discharge and rejoining society. Clinical observation of the ward context reveals a rather crowded setting with patients' exhibiting frustration, boredom, passive-aggression, and substance abuse. During weekly therapy sessions the predominant communication content relates to issues of discharge, ward conditions, alienation from family, and general feelings of powerlessness to achieve

their discharge. The roles of the facilitators are that of participant observers, implying that their participation also impacts on that which they observe. A systemic perspective which adopts a circular view on behaviour and its impact is used, implying that more effective behaviour results in more satisfactory subjective experiences.

Rationale

The decision to introduce an essentially non-directive music group was based on the following:

- Observation and identification of the behavioural *nodal point* (the observed behaviour most susceptible to change) of Ward 65 patients' as an inability to problem-solve effectively due to a perceived lack of competency and self-efficacy.
- An article by Longhofer and Floersch (1993), representing a study which focused on establishing an African polyrhythmic drum ensemble programme at two Kansas City (USA) community support programmes and its role in psychiatric rehabilitation.
- The rationale was to facilitate a sense of accomplishment (improving their sense of competency), to reinforce group identity (strengthening environmental support), as well as a general exploration of emotional expression (relief of frustration).

The facilitators offered their own drums for use and obtained a variety of other 'African-type' musical instruments, including shakers, marimbas, wood flutes, and a xylophone. A person-centered stance allowed the patients to express themselves freely. The facilitators actively took part by also using instruments to *follow* whatever *sound* the group generated. A culture of openness and trust was established.

Process

At the start of each session instruments were placed on the floor and the patients were invited to form a circle around the musical instruments. The following context was set only once: free expression of feeling and respectful use of the instruments. Thereafter the

context was based on whatever reflections the patients' offered about their experience. An open door policy was adopted, with the aim of showing interest as the only precondition for participation. Initially the group size fluctuated as patients' came to establish whether the music was 'for them or not.' After three sessions the group size stabilized at seven patients who regularly attended the remaining two sessions, and observably enjoyed the participation.

The group sessions evolved **from** *chaos and disappointment* **to** *helping each other* **to** *arguments, but also listening to each other* **to** *negotiation and communication with sound* **to** *enjoyment and silences*. A few extracts of the observed group process will be given after each session.

Session 1

Once the basic context was set, participants promptly selected instruments and experimented with them. They then briefly spoke amongst themselves and started singing familiar songs, namely Shambala and Nkosi, sikelel, i Afrika, and spontaneously used the 'sound' of their chosen instrument to compliment the rhythm. Two drums were used, mainly as the lead instruments; three patients' exhibited effective drumming technique. Instruments were freely and frequently changed. The pauses between songs were short and new tunes were introduced in a natural manner. Initially the 'sound' was mostly discordant and no planning behaviour was observed. The patients played for a full hour without prompting from the facilitators. At the end of the sessions the patients individually placed their instruments on the floor in front of the facilitators, exhibiting respectful behaviour.

Group processes observed

- Free interaction with the instruments (engaging in a new situation).
- Establishing some interaction about which songs to sing (intergroup normative behaviour as a pattern takes shape, as well as group identity that starts developing).
- Expression of the need to improve (aspiration).

Session 2

A fluent natural start with patients' no longer depended on familiar tunes. A drummer tentatively introduced a spontaneous rhythm which grew as others followed. Patients were observed to empathically and patiently demonstrate to other patients how to use the instruments (altruism, independence, and group cohesion). Even though the sound was still discordant and disjointed, patients appeared to be concentrating more in an attempt to improve harmony. There was an attempt to give the group a name but was not finalized. When one patient became disruptive another patient effectively controlled and defused the situation. It was observed that a drummer sub-group was forming and low-level rivalry was observed in terms of taking the lead and demonstrating proficiency in playing. A brief period for reflection prior to termination revealed that the activity was being subjectively experienced as relaxing, a welcome distraction, a comfortable encounter with people on a social basis ("like playing with friends and family"), and a challenge to make a better 'sound.' The patients unanimously agreed that the sessions should continue.

Group processes observed

- An attempt at creating a unique group product.
- Incorporation of other patients into the group.
- Effective inter-patient intervention to establish group conduct norms and to protect the forming group.
- An attempt to formalize group identity (name).
- Forming of a competitive element in terms of style and leadership.
- An investment in the future of the group.

Session 3

Fewer patients participated during this session. Taking the context from the previous reflection, the facilitators played a recording of West-African music (Baba Maal) and suggested a period for listening. After listening for a while patients used the instruments to play along with the recording. Another song was requested followed by playing alongside. Thereafter patients reverted to freestyle playing. The rivalry between drummers deepened and one drummer responded by drumming in an angry manner in an

attempt to take the lead, which resulted in a low-level argument which was defused when another drummer took the lead. Patients were observed to be increasingly making eye contact with others as they sought for a common sustainable rhythm. Interplay was observed and the facilitators recorded this. When played back at the end of the session, patients listened intently, showing surprise about the ‘sound’ they were achieving. A brief reflection period revealed suggestions about not playing all instruments together, but to vary it during a tune. Patients inquired about how the instruments were made and where they were obtained.

Group processes observed

- Claiming preference for own style of expression.
- Leadership struggle.
- Growing used to using the instruments to interact with other patients in a creative manner.
- Installation of hope for an acceptable group accomplishment.
- Planning to achieve said accomplishment.

Session 4

The session was characterised by patients verbally negotiating what to do next (planning behaviour). This was done in a relaxed and accommodating manner. The ‘sound’ produced was increasing harmonious accompanied by facial expressions exhibiting satisfaction. Very open playing postures were observed. The instruments were freely shared so that all had a chance to try a variety of instruments. It appeared that an inclusive norm had developed, since patients would hand instruments to those who ‘sat out’ and forewent playing for a while. This was accepted without any resistance. Interestingly, for the first time, the drummers competed in a different and more amicable manner. A drummer would produce a ‘sound’ and wait for another drummer to either emulate it or just respond in a spontaneous way, creating a circular musical interaction while looking at each other with excited expectancy. This was repeated several times by different patients and they visibly enjoyed it. The facilitators positively reinforced the group’s experience of satisfaction with their growing accomplishment. The group was also briefed that the group would terminate during the next session and that the playing

period would be followed by snacks and a bread ceremony. This was accepted without comment.

Group processes observed

- Exhibiting planned behaviour in a consensual manner (group action and group cohesion).
- Development of an inclusive norm to manifest cohesion.
- Experimented with different sequences of expressing emotions musically in an interactional manner.
- More pronounced sense of group accomplishment and emotional expression.

Session 5 (Final Session)

The facilitators reiterated that this was the final session and that playing would be followed by a bread ceremony and a social context. The patients started in an eager manner, and continued the trend of expressing their emotions musically while interacting with each other. Verbal communication was minimal and negotiations were musically rather than verbally introduced. It was also observed that patients experimented by their volume during a tune. Cooperative attitudes as well as greater spontaneity were observed. At this stage, a patient again introduced a suggestion for a group name, namely ‘The sky is the limit’ (claiming group identity). This name was accepted and a toast was made later to confirm the name. About half-way through the playing stage, when other patients who did not talk much were ‘sounding’, the patient who offered the group name became very talkative and was commented on by other patients in an empathic manner and was offered emotional support (cohesive support). A bread ceremony was conducted when the facilitators hung bread necklaces around the necks of group members as a reminder of their time in the group. A patient then volunteered to hang the remaining necklaces around the necks of the facilitators. The general group mood was tranquil and solemn. Patients expressed appreciation for the fact that the necklaces were made by the facilitators who accepted them in a dignified manner. Hesitation was observed in helping themselves to snacks. Only after the facilitators repeatedly invited them to help themselves did they oblige. A few patients discussed the possibility of continuing the

group with following interns (sustaining group identity). The patients appeared to linger when the time came to terminate and then quietly dispersed.

Group processes observed

- Confirmation of group identity and cohesion.
- Expressive interaction and further exploration of types of interaction.
- Anticipation of group resolution (a loss of group identity) followed by problem solving behaviour to sustain group identity.
- Possible contextual passive-aggression about the facilitators leaving the group (threat to group identity).

Concluding Remarks

Referring to rationale, it appears that a sense of group accomplishment, a group identity, and exploration of emotional expression was achieved in varying degrees. The facilitators became aware of their need to 'rescue' patients in their search for a form of expression and consciously refrained from continuing this behavioural pattern in order not to foster dependence. This resulted in them increasingly participating with whatever the group devised. On termination, the facilitators reflected on their subjective experience of guilt about 'abandoning' the group as well as helplessness about the patients staying behind in a closed system which may in all likelihood re-establish homeostasis. The supervisors agreed that they were personally impacted by the experience, since it questioned rigid perceptions of what comprises therapeutic intervention and planning. The general consensus is that their therapeutic repertoires and self awareness were enhanced.

7.5 Psychotherapeutic Approaches Used in the Semi-Open and Semi-Closed Wards

Weekly **group psychotherapy** is the highlight for most patients in the semi-closed and semi-open wards. The diverse psychotherapeutic approaches complimented with appropriate strategies that are used, are the same as in the open ward as discussed in the previous chapter.

7.6 Practical Issues in Training and Supervision

Patient variables, therapist variables, and context variables need to be carefully observed in the semi-open and semi-closed wards. For example the consulting rooms in the semi-open and semi-closed wards are not conducive for psychotherapy. The patient's personal problems and his frustrating experiences of the ward influences become blurred, giving rise to either manipulation, or the exaggeration of his symptoms.

Live supervision becomes particularly relevant in the restrictive environment of the semi-open and semi-closed wards. Montgomery's (1978) caution (refer to Section 4.13.1, Chapter4), that it "…*has been baffling - and a bit disconcerting – to learn a skill, and then use it in a consistently inappropriate manner at the wrong time, under the wrong circumstances, and for the wrong reasons*" (p. 28). Trainee therapists realize that for a real therapeutic relationship of trust to be established, techniques and strategies in themselves are sterile. The same goes for the reflecting of feelings. Problem solving and encouraging the patient to remain focused on the reality of his situation, become nodal points of therapy. The role of the social worker becomes particularly important for two main reasons. Firstly, because the Medunsa social worker only works in the open wards, so she is not directly available to patients. The psychologist often has to facilitate as a go-between the patient and the social worker. Secondly, the social worker's role of establishing family contact and of identifying a custodian needs to be arranged as soon as possible, in order to sustain the patient's hope of obtaining leave and being accepted back into the community again. It has been firmly established that the rehabilitation process is enhanced, when a patient's custodian attends a ward round. A good working relationship with the social worker thus becomes imperative.

The trainee psychologist also needs to establish a healthy working relationship with the nursing personnel, because the positive gains achieved in therapy can be undone after the therapy hour. For example a patient's new assertive behaviour is often seen as negative, aggressive, or relapsing behaviour by some nursing personnel. It therefore becomes

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important for the trainee therapist to communicate with the nurses in order to explain that the patient is in the process of adjusting to new ways of interacting.

7.7 Towards an Effective Multicultural Therapeutic Community

The fact that two different firms, namely Medunsa and UP Firms, have influence in Wards 65 and 66, has both advantages and disadvantages. Patients and staff see the differences in how patients are dealt with by the two firms. Patients clearly observe that the flow of Medunsa patients rotating through the wards is quicker than the UP Firm. This generates conflict for the nursing personnel who have to deal with the patients' frustration for the rest of the working week. For this reason the nursing personnel are always invited to the group meetings, firstly to understand first hand what the patients' concerns are, and secondly to explain their own position. Of course this situation presents itself as an opportunity for the Medunsa and UP teams to meet and dialogue. In the past nine years only three such meetings have been arranged. Unfortunately the meetings have been dominated by one authority figure, which imposes new ward rules, and expects all members to agree and abide by them. Open and free dialogue has not been encouraged, with the result that resentment and frustration on the part of team members was experienced, which quickly impacted on the patient's morale and total treatment process. A unilateral decision by one influential team member is often made, but is not necessarily in accordance with the central authorities' knowledge or agreement.

7.8 Conclusion

Of all the wards, the semi-open and semi-closed wards are the most interesting to work in. The reason being, that the patient's motivation is higher in these two wards because their next transfer would be to the open ward. Group discussions are normally lively and creative. Keeping within the ethnographic genre, and keeping in mind the "traps and tricks" cautioned by Thomas (1993), and also the criteria spelled out by Hammersley (1990) (refer to Chapter 2, Sections 2.5.8 and 2.5.9), the above chapter has portrayed detailed insights into the dynamics and processes of two types of group

psychotherapeutic settings. Although not conducive for individual psychotherapy, the patient's keen motivation for being transferred to the open wards allows for much creativity in the group psychotherapy sessions.

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CHAPTER EIGHT

PROFESSIONAL CULTURE-SHARING IN WARDS 22 AND 23

8.1 Introduction

Wards 22 and 23 are housed in the same maximum security land area of the hospital. For convenience sake, I shall refer to Ward 22 as the *Rehabilitation* Maximum Security Ward, and Ward 23 as the *Observation* Maximum Security Ward. Only male patients are housed in these two wards. The status of the male 'State Patient' while in the Observation Ward 23 is referred to as *the accused* or *the user*, since they have not yet been convicted by a court of law for their alleged offence. In the Rehabilitation Ward 22, the *State Patient* is referred to as *patient*, as stipulated in The New Mental Health Care Act (2002) which deals with the *Rights and Duties Relating to Mental Health Care Users* (patients), which emphasises the attitude of *respect and human dignity* which must be afforded to mental health care users (patients) by all staff.

8.2 Ward 22 Rehabilitation Maximum Security Ward

Ward 22 is where the State Patient is transferred to, after he has undergone psychiatric, psychological, and social evaluation while in the Observation Maximum Security Ward 23. The observation process in Ward 23 normally takes 30 days. Ward 22 is thus the first stage of the rehabilitation process after the accused has been classified as being mentally ill, after his 30 day observation period in Ward 23. Being the first stage of the rehabilitations process patients present with a variety of presenting symptoms and behaviours. Some patients are incoherent, inappropriate, and illogical (floridly psychotic), while others silently calculate how to be transferred to an open ward as soon as possible. Most patients deny that they have committed the alleged crime of which they

have been accused. In the weekly group psychotherapy sessions the patients are able to share their perceived injustices about the police and legal system, their anger at being kept in a hospital as a mentally ill patient, their impatience about not being seen regularly by the doctors, social workers and psychologist, and their frustration at not receiving free cigarettes from the hospital.

Some patients show *remorse*, and are serious and genuine in their attempts to understand and to improve their behaviour (I call to mind Andrew, Jabu, Ben, and Lucas). Others show *regret* and anger for being charged with a crime, and just refuse to talk about the circumstances that led to their alleged crime, or to acknowledge their disruptive behaviour in the ward, such as Skip Sithole, Simon Mabunda, and Jacob Zulu. It seems feasible, that for rehabilitation purposes, a classification system should be devised to separate motivated patients (regardless of their admission diagnosis), from resistant patients. It is true that currently a system exist that awards privileges, but it is neither consistently nor fairly implemented.

8.2.1 Psychotherapeutic Approaches Used in Ward 22

Group Psychotherapy

An open-door policy is adopted for the group psychotherapy sessions in Ward 22. Group sessions are sometimes chaotic, because of the presence of psychotic patients and new admissions. However groups are normally very well attended. Groups are structured, only when the needs of the group members and/or the psychologist requires structure. Otherwise the standard group norms apply when the group leader, often a patient says: "If you want to talk raise your hand. Don't speak out of turn. Please stick to the topic. If you want to go to the toilet ask me, the chairperson." Like Wards 65 and 66, the weekly groups are often the highlight in the patient's ward routine.

Individual Psychotherapy

A person-centered approach or stance is the standard attitude of the psychologist employed in all initial interactions, particularly in Ward 22. The central ingredients of

accurate empathic understanding (the therapist's ability to sense the inner world of the client's subjective experience), *unconditional positive regard* (accepting the patients as worthy persons despite their alleged crime), and *congruence* (the therapist's genuineness), remain the foundation of building a relationship of trust for the future of the patients rehabilitation process. By discussing the differences between the patient's internal and external frames of reference, the focus on the patient's own responsibility becomes a heated and regular topic of discussion in groups. Patients blame hospital staff, hospital rules, the police, members of their own family and community, and the laws of the country for not allowing dagga to become legalized. Several patients are adamant (Bekhi Apane) in their belief that it is their right to continue smoking dagga which is part of their culture. For some patients, because of their religious, rural, or cultural circumstances, the idea of taking responsibility for one's actions is a foreign concept, which becomes a limiting factor when working with these patients, a limitation inherent in the **existential approach** in working with culturally diverse client populations. However, in group therapy, there are patients who realize that they need to take responsibility for their own actions and subsequently challenge the other patients to do the same.

The following **limitations** of **gestalt therapy** apply when working with culturally diverse populations:

- Clients who have been culturally conditioned to be emotionally reserved might not see value in experiential techniques.
- Clients may be "put off" by a focus on catharsis.
- Clients may be looking for specific advice of solving practical problems.
- Clients may believe that to show one's vulnerability is to be weak.

Observed and interpreted within the **psychodynamic perspective**, the phenomenon of **transference** (that which arrives to replace a real relationship), or within the **ecosystemic perspective** (manoeuvring for a favour or for secondary gain), occurs regularly, and has to be dealt with in formal as well as informal contexts in the ward. Although it is a closed

ward, the patients are able to move freely around the spacious tract of land in which the ward is placed.

Behaviour, cognitive, and **cognitive behavioural** approaches have been effectively and creatively used in this first stage of rehabilitation, with most cultures, and for most disorders. One limiting consequence is when behavioural changes are made, without assessing the impact these new behaviours may have on hospital staff and family members. For example, staff and family members may not value the patients newly acquired style of being assertive. Patients thus need to be taught how to deal with the resistance by others.

8.2.2 Seclusion: Behaviour Modification or Punishment?

It is often said that seclusion has to do with patient compliance. When a patient deliberately and wilfully steps out of line, then he has to immediately be brought back to compliance somehow. On a continuum of withdrawing patient privileges, wearing pyjamas is on the one end of the continuum, while seclusion is on the other end. When seclusion is used as a behaviour modification intervention, based on sound clinical and research evidence, then it may fulfil a useful purpose. All too often seclusion is not prescribed appropriately. In a study that was initiated in Ward 22, but completed in another hospital, Carter (2003) found that the effects of seclusion were temporary in nature. "*Those patients who were studied showed brief compliance after seclusion, but rapidly returned to holding a defiant stance in relation to their environment* " (p. 80). Explained in ecosystemic language seclusion is not a therapeutic means of gaining patient compliance, but as "*…the final manoeuvre in a symmetrical struggle between staff and patient in order to re-establish a relationship that is defined in a complementary manner*" (Carter, 2003, p. 77). The wearing of pyjamas by physically healthy patients and the prescription of seclusion has varying effects on the patient's identity. Aspects relating to patient identity will be discussed in the next chapter.

8.2.3 A Visit to Prison

Patients perceive Ward 22 to be the same as a prison. Some patients have spent time in prison, either during awaiting trial, or as inmates for previous offences. I arrange an annual prison visit for the interns so that they can at least observe some similarities and differences between Ward 22 and prison. From a psychotherapist's point of view Weskoppies offers more therapeutic possibilities than the prison environment does. I do not have solid research evidence to support this statement, it is purely feed back that I receive from the interns every year. In any event, the challenge to motivate patients in the maximum security ward about the comparative comfort that they are surrounded in, in Ward 22 becomes a topic that is easier to handle in group discussions. The sections of the prison visited are:

- The Prison Museum;
- The Awaiting Trial section; Male and Female sections;
- The Convicted Male Inmate section
- The Convicted Female Inmate section; mothers and infants.

8.3 Ward 23 Observation Maximum Security Ward

As indicated in Section 8.1 above the Ward 23 *Observation* Maximum Security Ward houses males who have been charged with a criminal offence. These *accused* males (commonly referred to as *forensic* or *observation* patients) are sent by a court of law for an observation and evaluation period of 30 days. If found to be mentally ill *the accused* returns to court which sends *the accused* to a State Hospital for the mentally ill. If not found to be mentally ill *the accused* returns to court to continue with the trial. Two key factors which play a role in the accused's mental status are the aspects of *accountability,* and *trialability*. *Accountable* refers to whether the accused understood and appreciated the wrongfulness of his actions at the time of the offence; whether he knows the difference between *right* from *wrong*. *Trialability* refers to whether the accused is able to defend her/himself in a court of law, and whether s/he understands court proceedings. Female offenders who need to be observed are housed in the Female Closed ward

section. Because far fewer female offenders are admitted than males are, the female *accused observation* patients, are generally housed with other chronic female patients in a closed ward.

No formal psychotherapy takes place in Ward 23; only psychometric and clinical evaluations are carried out. A standard battery of psychometric tests and projective techniques are used, including the Thematic Apperception Test (TAT), the Draw a Person technique (DAP), the Rorschach projective technique, the Sacks Sentence Completion Test (SSCT), and the South African Wechsler Adult Intelligence Scale (WAIS / SAWAIS). A psychological report is written integrating all information obtained from the psychometric evaluation, clinical assessment and impressions, and the Interactional Pattern Analysis hypotheses (IPA). Finally the consultant psychiatrist integrates all information gained from the psychiatric, psychological, and social reports, and then submits a final report to the court, indicating the accused's status, regarding the *diagnosis*, *accountability*, and *trialability* details. This brings us full circle to where the State patient's rehabilitation starts.

8.4 Practical Issues in Training and Supervision

Regarding the observation ward, training and supervision for clinical observations, and psychometric assessment, the focus is on interviewing skills, and on the mastering of the principles and rationale of all psychometric procedures used. Interns are cautioned not to attempt any formal psychotherapy, although a person-centered stance is adopted in all initial interviews. At the same time sterile interviewing leads to resentment and resistance on the part of the interviewee, bringing to mind once again the caution of Denzin and Lincoln, (2005), that it is not enough to understand the mechanics of interviewing, and that it is also important "… *to understand the respondent's world and forces that might stimulate or retard responses. ... [the structured interview] often elicits rational responses, but it overlooks or inadequately assesses the emotional dimension*" (p. 703). The incidence of patients malingering is frequently observed in the course of forensic assessments, which generates much debate between MDT members, but also allows the

intern-psychologist to appreciate the finer nuances of interviewing, of listening, of interpreting psychometric testing results, of taking into account blood sample results, and of gaining information from the ward staff's observations.

8.5 Towards an Effective Multicultural Therapeutic Community

The long road towards rehabilitation begins after the mental health user has been evaluated in the observation ward, and has been transferred to Ward 22, which is the first stage in the rehabilitation process. Before being charged with his crime, the patient's dysfunctional behaviour was his sole form of adaptation in an environment, in which there was extreme confusion in the patterns of his communication. If the hospital becomes a substitute and an equally pathological environment, then it cannot be described as an effective therapeutic community. Old patterns of behaviour that have been habitually reinforced need to be modified, and Ward 22 is the place where it starts. The therapist's therapeutic attitude and spirituality that permeates the ward atmosphere is particularly evident when the patient first makes contact with the therapist in Ward 22.

8.6 Conclusion

Many of the crimes committed are gruesome, and can even be called evil, such as cannibalism, malicious murder, and child rape. Before healing and change can take place, perpetrators must acknowledge their crimes and reparations must be made. Remorse and reconciliation which is a part of rehabilitation is a lengthy process. *Remorse* has to deal with true sorrow and repentance, while *regret* has to do with, feeling uncomfortable for being "caught out." Without justice, our communities descend into violence, into a state of normlessness. In the following chapter, aspects dealing with normlessness, and virtue and evil are dealt with.

CHAPTER NINE

UNDERSTANDING THE PATIENT IN CONTEXT

9.1 INTRODUCTION

Hock (2005) aptly states that "*If one characteristic of human nature might be agreed upon by virtually all psychologists, it is that behaviour never occurs in a vacuum*" (p. 217). The author goes on to say that during the course of life, aspects such as, parenting styles, childhood behaviour expectations, family dynamics, friendship, interpersonal attraction, personal space, touching, sex, courtship rituals, marriage, divorce, love, hate, crime, and, cooperation versus competition are "*…all subject to profound cultural influences. So it is safe to say, that an individual simply cannot be understood with any degree of completeness or precision, without careful consideration of the culture in which he or she lives*" (p. 218). We need to keep in mind that culture refers to the *values* and *behaviours* shared by a group of individuals, which includes any one or combination of the following values that the individual strongly identifies with, namely, ethnic or racial heritage, age, gender, religion, education, sexual orientation, physical and mental ability, and socio-economic status. In this chapter I will deal with meta-influences inhibiting a multicultural therapeutic community, issues related to identity, virtue, and normlessness, in relation to treatment and training aspects. Finally, guidelines offered by three therapeutic models facilitating an effective multicultural therapeutic community, will be outlined.

9.2 META-INFLUENCES INHIBITING A MULTICULTURAL THERAPEUTIC COMMUNITY

In the majority of chapters thus far I have alluded to the idea of a multicultural therapeutic community. Wolcott (in Creswell, 1998) asks whether health workers are "*agents of change*", or if they are "*advocates of constraint*?" (p. 35). During their three

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month rotation internship period at Weskoppies Hospital, interns often echoed the likes of: "*If only the hospital can be seen as, and function as, a* ***community****, and* ***not*** *as an* ***institution****, then the reality of a therapeutic community may be achieved.*" Implementing such a vision requires the ability to *integrate* the *ordinary* and *fundamental concepts* of psychology, psychiatry, and the related mental health disciplines, with the more *refined and complex* theoretical and practical aspects of treatment.

Referring to the concept of a therapeutic community in which a therapeutic culture appropriate to the task and function of helping psychiatric patients, should be patient-centered, rather than the traditional doctor-centered frame of reference, forty years ago, Jones's (1968) commented that: "*It is difficult to understand why in the past psychiatry has been content to imitate the principles and practices of general medicine. As an example, psychiatric hospitals have much of the formal hierarchical structure of general hospitals, and relatively little attention has been given to their entirely different function*" (p. xi).

Extending beyond the hospital context, and taking a meta-perspective by looking into the influences that inhibit mental health in the broader multicultural community are current factors such as poverty, unemployment, and crime, together with health (HIV), and other social ills. One such ill is the widespread attitude of the *survival of the fittest* in a society in which normlessness (anomie) prevails.

9.2.1 Overcoming Anomie

During transformation in any society, values, morality, crime, and standards fluctuate; they go up or down, either temporary or permanently. As I am close to writing my conclusions and implications, I am aware of how a state of normlessness (anomie) has slowly been encroaching into many spheres of the South African context (Bateman, 2008a, 2008b, 2008c; Da Costa, 2007; De Ionno & Mokopanele, 2007; Gifford & Green, 2007; Govender, 2006a, 2006b; Govender, & Appel, 2006; Hosken. 2007a, 2007b, 2007c, 2007e, 2008a, 2008b, 2008c, 2008d; Otto, 2007b; Otto, 2008a, 2008b; SAPA &

Political Bureau, 2008; Saville, 2007; Sparks, 2007; Staff Reporters & Reuters, 2006; The Editor, 2007; Venter, 2008a, 2008b; Webb, 2007a), bringing to mind the apt title of one my prescribed criminology books, which I read as an undergraduate student entitled *Society, Crime, and Criminal Careers* (Gibbons, 1973). Crime has certainly become a lucrative career in South Africa over the past fourteen years. A very small percentage of the perpetrators get convicted, which means that the majority of reported criminal activities are reinforced and rewarded. Referring to the French sociologist Emile Durkheim (1858-1917) and the American sociologist Robert King Merton (1911- 2003), Gibbons (1973) describes anomie as that state of instability in society that threatens cohesion in a population. Emile Durkheim (Gibbons, 1973) suggested that anomie was likely to arise, when members of a social structure were denied adequate means of achieving the specific common goals that the society itself encouraged, such things as wealth, power, fame, and enlightenment (like the effects of apartheid in South Africa). As the condition of deregulation and normlessness develops, sudden depression, sudden prosperity, or sudden technological advancement occurs. *Sudden depression* occurs when people cannot readily adapt to their reduced state of existence. *Sudden prosperity* occurs when new opportunities "... *lure some individuals into supposing that they can attain seemingly limitless wealth and achievemen*t" (p. 183).

An example of how two laws can create confusion, cognitive dissonance, anger, and distrust in the minds of people, are the Sexual Offences Act, and the Abortion Law. The recently passed Sexual Offences Act criminalizes any light sexual behaviour engaged in, by those under the age of 16. "*…the act makes it illegal for the youngsters to kiss, touch or rub against each other*" (Naidoo & Packree, 2007). Public opinions are mixed. Some say that it is useful because it teaches teenagers the value of mutual respect as they mature into adults, while others say that it is a ridiculous law, inhibiting adolescents from showing natural and spontaneous affection. Nevertheless, when seen in the light of the country's abortion law, it makes no sense to legalize abortion (murder of an unborn life), and then criminalize affection, which only, may lead to the sexual act.

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Because of the *multifaceted issues* involved in understanding and preventing crime, *the systems perspective* is useful, because it allows researchers to observe the crime phenomena from several meta-positions. The possible usefulness of a *systems perspective* is reflected in Viljoen's (2006) critical discussion of South Africa's crime prevention model, namely, the National Crime Prevention Strategy (NCPS), in which he asserts that: "*Systems theory is the only model that captures the complexity of crime*" (p. 252).

9.2.2 Force Field Analysis: An Idea Borrowed From Industrial Psychology

Regarding the internal workings of the hospital system, the general purpose diagnostic technique, of *force field analysis*, is an invaluable tool to identify the limiting and facilitating factors inherent in the system. By using the basic principles of *force field analysis* (Brown & Harvey, 2006) which is regularly used in the field of industrial psychology to identify the limiting and facilitating factors inherent in a system, can help to bring about optimal functioning in any system (Brown & Harvey, 2006). Kurt Lewin (Carr & Kemmis, 1986), who coined the phrase *action research* (refer to Section 2.3.5, Chapter 2), which describes the group decision making process in terms of *planning, fact finding* and *execution* towards solving a problem, also developed the diagnostic technique, of *force field analysis*. In the hospital setting, the limiting and facilitating factors can easily be identified, in order to bring about optimal results in the desired therapeutic outcome of patients, the morale of staff members, and in the improvement of all other hospital activities.

9.3 UNDERSTANDING THE PATIENT

Bugental (1987) captures the essence of understanding and caring when he states that: "*The most fundamental skill of the psychotherapist is productive listening. Everything else the therapist does need to be founded on his developed ability to hear on many levels simultaneously. Such listening is more than just passive recording; it is a dynamic alertness which involves many sense modalities plus intuition, reflection and cultivated*

empathy" (p. 71). Patients do speak and express themselves in their home language, but more importantly, they also speak the language of suffering, which requires special listening skills, because the language of suffering contains many symbols. When we do not understand what they are saying, to call them crazy is meaningless, because there is always a reason why they say and do things. When we take the trouble to look at the total context in which their behaviour occurs then we will certainly see that their behaviour is not meaningless (Rosten, 1961).

It is therefore worthwhile to understand rehabilitation from the patient's perspective. Creswell (1998) observes that there is a lack of caring evident in the health system today as a result of not understanding the patient's perspective. Once patients are admitted to a hospital "*… there is a strong tendency for them to be viewed in ways that ignore their individuality* (Hock, 2005, p. 230). The attitude created is that if they are in the hospital then they must be crazy. More importantly is what Rosenhan (1973) refers to as the *stickiness of the diagnostic label*, which means that when a patient is for instance labelled as schizophrenic, the label becomes his or her central characteristic or personality trait. From the moment the label is given, the staff focuses only on the label. Consequently staff members perceive all of the patient's behaviour as stemming from her/his diagnosis.

Friends of Weskoppies

There are groups of people in the community who devote time, talents, energy, and money to develop and enhance the well-being of the Weskoppies patients. For example soccer, putt-putt, and jukskei (yoke-pin) terrains are developed and maintained, and sports equipment is purchased. The funds and the talents of the *Friends of Weskoppies* are employed at Annual Christmas parties, the bi-annual fête, visits to the Pretoria show and Zoological gardens, and arranging regular braais (barbeques). During these informal social gatherings, patients are able to interact more freely, and thus be understood in a wider context, because their identity and individuality are able to be expressed more fully.

The Bi-Annual Fête

The fête has the dual function of providing fun and entertainment especially for chronic patients, and to raise money for the patient's fund. The atmosphere is generally relaxed. The clinical tone is absent. All participants dress colourfully, patients and staff alike. The organizational structure adds to the success and smooth running of the fête. Instead of ward, files, and documents, the atmosphere is replaced with stalls selling hamburgers, foods, and artefacts made by patients during their Occupational Therapy programmes. Caravans are strategically placed to collect money for coupons. Patients are given sufficient coupons for eats and drinks, but patients try and exchange coupons to obtain cash to buy cigarettes. In May 2005 I won a prize in the big walk while a patient who was ahead of me in the walk was disregarded. I had been talking to and walking with several patients during the 3 kilometre walk, so it was easy to witness and share the injustice of the favouritism that had taken place. So, with some of the participants in the walk, I arranged an independent prize-giving opportunity, and awarded my prize to the patient who had rightful earned it.

9.3.1 Open Wards Open Minds and Open Communication

The acceptance of open and closed wards goes hand in hand with open and closed minds, and open and closed communication. The restriction of the physical freedom in a closed ward invariably gives rise to closed minds and closed communication. Instead of the healing atmosphere of the hospital institution becoming therapised, the therapy now becomes institutionalized. The healer becomes institutionalized instead of the hospital institution becoming a place of healing and rehabilitation.

The theme of openness and of professional autonomy in hospitals has been encouraged by many authorities. Within the context of *open mind* and *open communication*, psychiatrists such as Foudraine (1974) and Jones (1956, 1968), have questioned similar issues, and have to a certain extent influenced other health professional's attitudes towards psychotherapy and mental health in general. Within the global context of *open mind* and *open communication* the three accounts of Harry Stack Sullivan, Jacob Moreno,

and Carl Rogers (Chapter 6, Section 6.7), are examples of how their attempts to "make things better", eventually culminated in the sharing of their ideas in the larger systemic context of working toward, and helping humankind to work towards world peace.

Sometimes the home and community system from which the patient comes, have been healthy and functional, sometimes dysfunctional, and sometimes evil like in Satanism. Sometimes the perpetrator or the victim became a patient through his or her own deliberate wrong choices, sometimes through unconscious processes, self handicapping and self defeating behaviour, or through lack of insight, or as a result of careless and faulty judgement. Sometimes a person became a victim because s/he had become caught up in an evil system or interaction like satanic rituals involving child abuse, incest, wilful murder, and child rape. The question of identifying with positive and negative, functional and dysfunctional, good and evil becomes relevant at this stage of the discussion.

9.3.2 Identity and Virtue

Positive psychology (Snyder & Lopez, 2005) and Virtue psychology (Fowers, 2005) emphasise the goodness and wholesomeness of psychotherapy, while not ignoring the pathological aspects of human behaviour. Positive psychology is the scientific study of the strengths and virtues that enable individuals and communities to thrive (Snyder & Lopez, 2005). Bateson (1976) for example observed that: "*Those who lack all idea that it is possible to be wrong can learn nothing except know-how*" (p. 26). Learning *know-how*, easily translates into learning strategies and techniques in the absence of adhering to healthy acceptable professional, ethical, legal, and moral principles and guidelines (Allan, 2001; Burke, Harper, Rudnick & Kruger, 2007; Lindegger & Stobie, 2004; Prozesky, 2006).

One reason why patients conform to hospital rules may be seen in the context of establishing their identity. For example, within a multicultural context, Muller and Nieuwoudt (2003) explain that "*When one fulfils the requirements of the identity that one's culture sponsors, one is rewarded with 'good' personal feeling*s" (p. 337). Still

within the context of identity within a multicultural setting, Muller and Nieuwoudt (2003) summarise their findings by stating "*The places we live our lives, the people we interact with and the culture we are born into all play a role in our quest to answer the question 'Who am I?'*" (p. 344).

A person's personal identity is just as important as his personality characteristics (Roos, 2006). A prolonged traumatic or stressful situation or influence undoubtedly impacts on a person's identity. The person's self concept and self image undergoes change. While weighing up *identity* with *personal characteristics*, it is important to note that when Gordon Allport developed his model of personality he eradicated the idea of good and evil, from personality development (Allport & Odbertt, 1936). When Allport and Odbert (1936) developed their comprehensive catalogue of 18,000 human traits from the unabridged dictionary, they deliberately excluded evaluative trait terms such as *character* and *virtue* (Cawley III, Martin, & Johnson, 2000). Consequently, evaluative terms such as *character* and *virtue* were left out of early important theoretical models of personality. Currently the literature on Virtue and Psychology (Cawley III, et al., 2000; Fowers, 2005) addresses the ethical issues in clinical psychology including the good and evil influences that psychologists may consciously or inadvertently bring into people's lives. Virtues are character strengths such as generosity, loyalty, and honesty, which make it possible for people to pursue worthwhile goals. The virtue of practical wisdom (prudence) enables one's ability to choose one's actions wisely, thereby illuminating therapeutic practice, research, and professional ethics (Fowers, 2005).

Identity is an umbrella term used throughout the social sciences for an individual's comprehension of her/himself as a discrete, separate entity. Identity in psychological terms relates to self-image, self-esteem, and individuation, which dictates to some degree how a person views her/himself as a person in relation to other people.

And so it is also evident that all sorts of people are attracted to psychiatric hospitals for all sorts of reasons, in order to establish and develop their own identity, either consciously or unconsciously:

- some to become great clinicians at the expense of patients;

- some to become great clinicians at the expense of challenging the system;
- some to become great administrators at the expense of ignoring the needs of patients and staff;
- some to become great administrators at the expense of trying to make the therapeutic environment more functional;
- some to become great patients at the expense of giving up their identity and learning to play the hospital game;
- some to become great patients at the expense of struggling to retain their integrity and finally becoming understood by the powerful others in the system;
- some to obtain employment and earn a salary in order to maintain their lifestyles;
- some to obtain employment and earn a salary in order to truly use their skills to assist the suffering;
- some to obtain credentials, qualifications, and experience to enrich their personal goals and their CV,s;
- some to obtain credentials, qualifications, and experience in order to enrich the therapeutic environment in which they are a part.

When we mental health workers recognise our motives for choosing to work with patients in need of psychological and psychiatric help, then the chances of transference and counter-transference occurring will be minimized, thereby creating the possibility of a *real* therapeutic relationship. At the same time ethical, moral, and legal issues in all the above selfish and selfless motives exist (Allan, 2001; Fowers, 2005; Snyder & Lopes, 2005).

9.4 TOWARDS AN EFFECTIVE MULTICULTURAL THERAPEUTIC COMMUNITY

The following **three** models offer guidelines which may be implemented in multicultural psychotherapeutic contexts. The commonalities in each model emphasise the importance of the common features regarded as central in all three models.

9.4.1 Corey's Contribution in Becoming an Effective Multicultural Therapist

By focusing within three areas, namely, *Beliefs and attitudes*, *knowledge*, and *skills and intervention strategies*, Corey (2005) offers guidelines that may assist counsellors and therapists in sharpening their sensitivity and in the development of their multicultural skills.

Beliefs and Attitudes: Culturally sensitive therapists realize that traditional forms of therapy are not always appropriate for all patients and for all problems. Culturally skilled therapists accept and respect the value of the cultural diversity in all people. The effective therapist does not allow his or her own biases and preferences to interfere with establishing a collaborative therapeutic relationship, with patients who are culturally different from him or herself. The culturally skilled therapist keeps this therapeutic aliveness through self awareness, personal consultation, and further training and education. The effective therapist needs to challenge any psychological blind spot s/he may have.

Knowledge: Culturally skilled therapists are knowledgeable about all aspects of the patient's world view and the socio-political system in which the patient functions. This knowledge includes how to make use of indigenous support systems, the dynamics of oppression, racism, sexism, discrimination, exploitation, and the social and institutional barriers that prevent the patient from receiving optimal benefit from available health services. The greater the therapist's depth and breadth of knowledge of all influences in the socio-political system that impacts on the patient's functioning, the more likely s/he is likely to be an effective clinician.

Skills and Intervention Strategies: Multicultural counselling and therapy is enhanced "*…when practitioners use methods and strategies and define goals consistent with the life experiences and cultural values of their clients*" (Corey, 2005, p. 25). The skilled therapist is able to adapt techniques and interventions in a creatively and responsible way

to blend into the patient's cultural repertoire. The therapist's physical, (mainly non-verbal), and psychological, (mainly verbal), ways of attending to the patient, as outlined for example by Egan (1975, 2002) are valuable guidelines which may be used in the contexts of diversity and multiculturalism.

9.4.2 Brooks-Harris and Gavetti's Multicultural Psychotherapy Strategies

In an elaborate integrative, multitheoretical model which includes multicultural aspects, Brooks-Harris (2008) and Brooks-Harris and Gavetti (2005a, 2005b, 2008) incorporate their diagnostic, treatment, and strategic dimensions, within the following seven theoretical approaches.

Cognitive psychotherapy, which focuses on **thoughts**, the evaluation of beliefs, and the encouragement of adaptive thoughts.

Behavioural psychotherapy, which focuses on **actions** and the reinforcement of adaptive patterns of behaviour.

Experiental psychotherapy, which focuses on **feelings**, personal experiences, and human potential, and strategies to promote awareness and encourage adaptive feelings.

Biopsychological psychotherapy, which focuses on **biology** and mind-body awareness, and strategies to support adaptive health practices and holistic wellness.

Psychodynamic-Interpersonal psychotherapy, which focuses on **interpersonal patterns** and perceptions, and strategies to encourage undistorted interpersonal perceptions.

Systemic-Constructivist psychotherapy, which focuses on **social systems** and the social construction of meaning, with strategies to encourage the adaptation to social systems.

Multicultural psychotherapy, which focuses on **cultural contexts**, gender and identity, with strategies which encourage adaptation to cultural contexts and to support adaptive cultural practices and values.

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The following 14 multicultural psychotherapy strategic guidelines have been outlined by Brooks-Harris and Gavetti (2005a, 2005b).

i Clients need to be *viewing culturally*, which means that their thoughts, actions, and feelings need to be observed and understood from their own cultural point of view.

ii The *impact* of the *client's culture* needs to be *clarified*. The impact of the cultural context and family background of the client's current functioning and interpersonal relationships need to be clarified.

iii In order to help clients accept and express their *uniqueness*, the diversity and uniqueness of their culture needs to be appreciated and *celebrated.*

iv Facilitating the *awareness and development* of how the client's *cultural identity* has developed, promotes self-acceptance and empowerment.

v Enabling clients to recognize how their *identity development* has i*mpacted* on their personal success and failure.

vi Enabling the client to appreciate the *interaction* between *multiple identities* including race, ethnicity, gender, sexual orientation, class, ability, and age.

vii Highlighting the *impact* of *societal oppression*, privilege, status, and power on *thoughts, feelings*, and *actions*.

viii *Creating an Egalitarian Collaboration* whereby the therapeutic relationship highlights and outmanoeuvres the power dynamics found in society.

ix *Exploring societal expectations* and supporting informed decisions in order to decide which social roles to embrace and which to discard.

x *Integrating* a client's *spiritual awareness* of faith development into his total and holistic growth.

xi Psychotherapists are expected to understanding their *own worldview* and how it impacts on their role as a psychotherapist.

xii Presenting therapeutic *options* with as *little bias* as possible.

xiii Illuminating the differences between psychotherapist's and the client's identity and clarifying how they impact on the therapeutic relationship.

xiv Supporting clients who participate in social action, in order to understand, adjust to, and work towards change against oppressive societal structures or practices.

9.4.3 Valdez's Theory and Model of Multicultural Psychotherapy

Valdez's (2006) theory and model of multicultural psychotherapy, centres around three aspects, namely, *theoretical orientation*, *process*, and *issues*. Valdez's model is not as elaborate as the integrative, multitheoretical model offered by Brooks-Harris and Gavetti (2005a, 2005b, 2008). Valdez's (2006) model has much in common with Corey's (2005) and Brooks-Harris and Gavetti's (2005a, 2005b, 2008) models, but is more loosely arranged, and eclectic in its application.

9.4.3.1 Theoretical Orientations

Valdez (2006) accepts all traditional psychotherapeutic approaches, namely psychodynamic, humanistic, behavioural, cognitive, biological/medical, and systems approaches, to understand personality development, identity formation, indigenous cultural perceptions, in order to arrive at a diagnosis, therapeutic goals, and relevant treatment plan. Valdez (2006) however cautions that the implementation of the model needs to be modified and refined in all clinical settings.

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9.4.3.2 Process Conditions

During the process of psychotherapy, Valdez (2006) groups 14 process aspects, which need to be monitored and attended to, of which I will discuss under two main themes namely, *sensitivity to cultural nuances*, and the *significance of life experiences*.

Sensitivity to Cultural Nuances: When working with clients who are different to the therapist's own culture, therapists should be aware of how the client's physical features and body build, for example, the clients skin colour, hair texture, eyes colour and shape, accent, fluency in English, and socioeconomic factors such as level of education, occupation, and income, arouse thoughts, feelings, and behaviours in the therapist, which are different from those thoughts, feelings, and behaviours that occur when working with a client who is more like the therapist's own cultural preference.

The more the values, attitudes, and behaviours of the client deviate from the mainstream dominant culture, the more an *ethnic minority status* increases in the client, which may increase and intensify feelings of doubt and incompetence in the trainee therapist, thereby lessening the effectiveness of the trainee therapist.

Significance of life experiences: This involves knowing about the significant life experiences that influence the client's every day thoughts, feelings, and behaviours. Life experiences include those that have been historically experienced by the client's family and cultural group, as well as all the internal psychological processes, and external environmental pressures and stresses that the client has to deal with on a daily basis, needs to be understood and dealt with.

9.4.3.3 Issues

Oppression: For example the impact on the person's functioning as a result of the oppression of minority groups, including any form of discrimination like apartheid and affirmative action.

Helplessness: This aspect includes the oppressive effects of rigid, governmental, departmental and hospital rules, ward protocol, and lack of support from family and community members.

Stigma effect: For example the difficulty in obtaining employment after discharge from a psychiatric hospital.

Coping: Coping with the adjustment issues after life after discharge, and with the new behaviours learned during the process of psychotherapy.

Integrating information gained from ward rounds, clinical assessments, psychometric assessments and all collateral information, will determine which and how the guidelines of the above three multicultural models (Brooks-Harris & Gavetti, 2005a, 2005b, 2008; Corey, 2005; Valdez, 2006), should be implemented to achieve the suitable therapeutic goals. The above three models contextually describe and outline the *cognitive*, *affective*, and *behavioural* factors described by Corsini's (1995, 2005, 2008) mechanisms and ingredients of psychotherapy discussed in Chapter 3.

In Mngoma's (2001) qualitative study of three State patients in Weskoppies Hospital, she identified thirteen factors which contributed towards their relapse. Eight factors were evident in all three subjects, namely the *quality of the relationship with family members*, *communication difficulties*, *substance abuse*, *non-compliance to medication*, *lack of family support*, *poor insight and judgement*, the use of *defence mechanisms*, and feelings of *isolation and rejection*. Three factors played a role for two patients, namely, *stigma*, *labelling*, and *suicidal ideation*. *Peer group pressure* played a significant role for one patient, while the influence of *traditional and cultural methods of healing* was a significant factor for one patient. Although the study was carried out with three patients, the influence of the abovementioned thirteen factors are spontaneously and regularly brought up by patients to be discussed in the weekly psychotherapy group sessions.

9.5 CONCLUSION

Patients as well as staff need structure and certitude as well as informed and confident leadership. In my own experience in the past 27 years, the real challenge has been to make psychotherapeutic interventions within and according to the patient or client's immediate circumstances, context, and system in which s/he functions. The systems may include the patient's relationship within her/his culture-sharing groups of the family, the legal system, the school or university context, the work place, the hospital, the community, or society in general. Dealing with conditions ranging from, personal fears, phobias, and obsessions, to substance abuse, to relationships within the family, to forensic matters, to involvement with Satanism, always takes place within interaction with other people. By adopting an ecosystemic stance, has been helpful and conducive in the understanding of the patient in his or her immediate context. Listening skills are the foundation on which every other psychotherapeutic intervention and strategy is based (Bugental, 1987; Corey, 2005; Egan, 1975, 2002).

As psychotherapy has developed over the past century it has become evident that a new code of psychological treatment, rooted in all strategies, ethics, and techniques of healing, is required to support and sustain treatment and rehabilitation programmes in mental health. In my experience it has been observed that the goodness of all the available therapeutic expertise in the hospital does not reach the patients. Many patients are impoverished in the midst of an ocean of therapeutic knowledge and experience. Some ways in which such therapeutic knowledge and experience may be addressed and achieved, and made available to patients is dealt with in the next chapter.

CHAPTER TEN

CONCLUSIONS, RECOMMENDATIONS, AND FUTURE DIRECTIONS

10.1 INTRODUCTION

No scientific book, journal article, dissertation, or thesis has the final word on its subject matter. All knowledge in the form of published and unpublished information, facts, and opinions add to the collective truth and reality of the topic under discussion. As I reflect on what I have written, it remains clear to me that a hospital culture in which a therapeutic community operating in collaboration with a multidisciplinary team, comprising of clinical psychologists, psychiatrists, social workers, occupational therapists, psychiatric nurses, and administrative staff, working towards the same therapeutic goals, addressing the multicultural influences in the hospital, is a practical, and wholesome context in which patients will benefit. Keeping within the ethnographic ethos, several recommendations, suggestions, and implications have already been interspersed throughout the ethnographic inquiry in previous chapters of this thesis.

To develop the art of writing in a tone that is not offensive, defensive, or aggressive, but which reflects and communicates the problem, is indeed necessary when making recommendations in the field of mental health. My intention is to confront the problem, and not the people in the field who are trying their best under trying circumstances. I trust that the under mentioned reflections, considerations, and recommendations will arouse interest, discussion, and dialogue. The remainder of this chapter deals with the relevant ethical considerations and recommendations applicable to mental health in the South African context.

10.2 RECOMMENDATIONS AND ETHICAL CONSIDERATIONS

Clinical psychology is subject to a code of ethics, which involves aspects related to professional conduct, law, morality, and virtue psychology. As part of the larger system, decisions made by any Professional Board of Psychology, are influenced by local, national, and global bodies. Prozesky (2006) asserts that "*All would agree that there is an obligation on us to produce skilled clinicians who will treat patients safely. Not to do so would be wrong – so we have a moral position here*" (p. 1).

The following recommendations and ethical considerations flow from what I have written thus far, and from my involvement in psychiatric hospitals for the past 16 years.

10.2.1 Psychological Treatment

The Golden Rule of psychotherapy, namely, establishing a relationship of trust, reflected in the therapist's empathy, warmth, and congruence is a summing up of what every clinician/theorist has always known to be effective. According to my clinical experience and perusal of the literature, really great psychotherapists never introduce new basics; it is quacks and cranks who do that. The basics remain constant. Mental health workers need to be *reminded* more often than they need to be instructed. The real job of every good clinician is to keep on bringing us back, time after time, to the established ordinary, basic, and simple principles, which many of us are so anxious not to see, admit, or acknowledge.

Clinicians need to remember that *nouns* (people, qualifications, and credentials) don't heal, but that *verbs* (actions in the form of empathy, warmth, and sincerity) heal. Psychotherapists will never fully understand the power and influence of psychotherapy, unless we fully grasp the nature of our total attitudes and actions inside and outside of the therapy contexts. Corsini and Wedding (2008) shed light on this aspect in their reference to being a *real* person and being a *real* therapist. Raymond Corsini (Corsini & Wedding, 2008) got to know Carl Rogers and Jacob Moreno personally, and states that "*Rogers,*

whether in his social life, as a teacher, or as a therapist, was exactly the same. He and his system were identical … There is no question at all about the congruence of Moreno's unique personality and his methodology. Again the system and the man were identical" (p. 13). For example *authenticity* and *warmth* is not a static state whereby one is either in or out, but a quality that is built or lost over a lifetime of struggles and choices. At the same time *compassion* may be described as "your pain in my heart." and requires a generous amount of other-centeredness. The thought of compassion is much more appealing than the actual deed. Lauded in politics, medical circles, religious communities, large corporations, and educational staffs, compassion does not always get put into action

10.2.1.1 Ethical Considerations Relating to the Hospital

Kurt Lewin (Foudraine, 1974) has stated that, "*If you want to know how things really are, try to change them*" (p. iv). Within the hospital culture (a social system), any health professional including the psychologist may facilitate as a cultural reformer, a social engineer. If the reformer succeeds a new community springs up. The trouble is that as soon as he departs the ward gradually sinks back into the old traditional form of organization. Of course this is interpreted as patients relapsing and not that the MDT might not be working effectively. Traditions are generally rooted in the following constructs, which may remain static or may change as a result of cultural reforms during the process of transformation:

- *Truth*: Religious convictions, scientific discoveries, facts;
- *Habit*: Bureaucracy, hospital protocols, ward rules
- *Practical Convenience*: Because it works, relativism.
- *Arrogance*: Men are cleverer than women, psychiatrists know best, patients always manipulate;
- *Prejudice*: It will never change; it has always been like that.

The balance between stability (control vs. order) and growth in a therapeutic system in which rehabilitation is the goal, means establishing equilibrium (stability) and then

moving forward (growth). Human rights are a key concern nationwide. The New Mental Health Care Act No 17 (2002) as often discussed at meetings in Weskoppies Hospital, exposes the reality that the hospital is a restrictive environment, and that medication is not always effective. At these meetings it has been suggested that all professions must take responsibility for treatment and decision making, when the problem falls in the relevant therapist's field. However a restrictive environment with multiple leadership, open communication, and a dedicated multidisciplinary team, will overcome many restrictive attitudes and mindsets, on the part of all personnel. Multiple leadership means the delegation of therapeutic responsibilities to the relevant specialist, much the same as in the case in private practice when a patient is being referred, sometimes for an opinion, and sometimes for total handling. It must be a team effort.

It is significant to note how the role of ethics in medical training has taken on a fresh dimension in the University of the Witwatersrand. In his inaugural lecture on ethics and morality in the medical profession, Prozesky (2006) outlines the importance of producing ethical practitioners in the health care profession. Knowledge and skills are needed, but motivation and compassion make a great difference to the way a health care practitioner carries out her/his work. Prozesky (2006) summarizes the contents of the new medical curriculum by stating that "*…on the one hand the clear definition of objectives in knowledge and skill, and on the other three ongoing themes which deal comprehensively with the 'attitudes' aspect: learning to relate to patients, to communities and to the profession*" (p. 1).

10.2.1.2 Ethical Considerations Relating to the Hospital Staff and Patient Care

Optimal medication as well as optimal teamwork is necessary. Hospital personnel who are overworked cannot facilitate adequate patient care. In view of the shortages of trained personnel (Bernstein & Johnston, 2007; Caelers, 2005a, 2005b; Cullinan, 2006; Da Costa, 2006; Govender, 2005b; Green & Tau, 2005; Hosken, 2006d; Keeton, 2007; Nthite & Du Plooy, 2006; Otto, 2006b; Venter, 2005), full use should be made of ancillary help. The concept of the therapeutic community draws attention to the need to

make the optimal use of the potential in trained staff, volunteers, patients, their relatives, and any other people with a contribution to make to the betterment of mental health, for example the Friends of Weskoppies (Section 9.3, Chapter 9). The New Mental Health Care Act No 17 (2002) clearly spells out the physical, mental, and social well-being that mental health services should provide and the importance of respect, human dignity, and privacy in patient care. Clinicians, with adequate knowledge, skills, and a therapeutic attitude are needed to fill the present shortage of skilled personnel. In recent years there is however an increase of more blacks being attracted to the psychiatric profession (Mthembu, 2004).

10.2.2 Psychological Training – Academic Aspects

It is proposed that all relevant and effective psychotherapeutic approaches be taught including the central aspects, of the Integrative, Transtheoretical, Multicultural, and Ecosystemic approaches. The recommendations of the Boulder Conference should be kept in mind, in which the *Scientist-Practitioner Model* (refer to Section 4.11, Chapter 4), proposed that clinical psychologists be trained as scientists and as practitioners, not in professional schools but in traditional academic institutions. This places the responsibility on Universities to cultivate a scientist-practitioner attitude during all academic levels of training.

10.2.3 Psychological Training – Practical Aspects

Psychotherapy supervision is essentially "…*an intervention that is provided by a senior member of a profession to a junior member or members of that same profession*" (Bernard & Goodyear, 1992, p. 4). Furthermore psychotherapy supervision serves a critical *quality control* function, ensuring that, patients are provided with acceptable care, therapists do no harm, therapists possess sufficient skills to function as 'therapists', and those who lack such skills are not allowed to continue without some form of remediation (refer to Section 4.13.2, Chapter 4). In South Africa the requirement of the CPD point system (Continued Professional Development), would ensure this type of remediation.

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Related practical aspects to the training of psychotherapists are the following:

- Psychotherapists and the leaders of mainstream mental health professional organizations should make efforts to engage in more constructive relationships with members and leaders of the community and political sectors, which could lead to increased referrals from these sectors, and to gain more respect and trust from the general public. Gaining additional insight into a member's expectations and perceptions can assist mental health workers, and community and political leaders in clarifying prejudices and misperceptions about each other. There is reason to believe that their support and assistance can significantly *enhance* and *maintain* the outcomes of psychotherapy if used appropriately. This could also lead to increased credibility, influence, and stature in society.
- For patients it could increase the likelihood that they will receive the mental health services they need from someone who truly understands their perspective and who does not automatically interpret their beliefs (culture) in pathological terms.
- Increased education and training in cultural diversity is essential.
- In addition to training there is a need for increased research on how mental health professionals can work more effectively in order to bridge the gap between bureaucracy and clinical practice. Although substantial efforts along these lines have been made over the years within some professional organizations, relatively little has been published about these topics in mainstream psychology journals.

10.2.3.1 Ethical Considerations Relating to the Psychological Profession

The ethical guidelines for clinical psychologists are clearly outlined by the Ethical Code of Professional Conduct (2002) as stipulated by The Professional Board for Psychology (HPCSA). Psychotherapists need to be *reminded* more often than they need to be instructed of their professional and ethical conduct. Rules and regulations exist to show us the way, to point to the bare minimum standards of ethical behaviour; when followed they establish order but are no guarantee for the health and rehabilitation of patients. The

following additional guidelines have been suggested by psychotherapists in the field of ethical and professional conduct for psychotherapists:

- The *law* and psychotherapy (Allan, 2001).
- Establishing an *ethical character*. In addition, moving beyond statutory ethical codes. Burke et al. (2007) emphasise ethics as a contextual, character-based enterprise. This aspect directly relates to Prozesky's, (2006) attitude of motivation and compassion on the part of the health worker (refer to Section 10.2.1.1above).
- In Lindegger and Stobie's (2004) ethics workshop they remind psychologists that "*to satisfy the law is cheap but to satisfy ethics is expensive*."
- Brooks-Harris (2008), Brooks-Harris and Gavetti (2005a, 2005b, 2008), Corey (2005), and Valdez (2006) outline specific ethical guidelines regarding multicultural issues.

10.2.4 Governmental Policies Regarding Mental Health Care

Traditions, authority, organizations, and structure have their uses, but when these aspects are mindlessly transplanted into an organization in which the function is different, then reform needs to be implemented. Keeping in mind Jones's (1968) assertion that: "*It is difficult to understand why in the past psychiatry has been content to imitate the principles and practices of general medicine. As an example, psychiatric hospitals have much of the formal hierarchical structure of general hospitals, and relatively little attention has been given to their entirely different function*" (p. xi), new policies need to be integrated into the hospital culture (Foudraine, 1974; Jones 1956, 1968; Peyton, 2003). It is therefore appropriate to invite and challenge authorities and professionals to call for a *transformation* in health policies *not* just an improvement. Taking into consideration the staff shortages and the 'brain drain', mental health care is in need of a boost (Cullinan, 2006).

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10.2.4.1 Ethical Considerations Relating to the Department of Health

Clearly the optimal interaction of medication, teamwork, and the contribution from all community members, has not been happening on a regular and ongoing basis. According to local newspaper articles (Editorial, 2006) a *Skills Revolution* is indicated, but at the same time it is argued that *experience cannot be fast-tracked* (Goddard, 2006). In my opinion the already skilled and experienced clinicians need to be given the incentive to effectively implement the concept of *true multiple leadership* in the already established therapeutic communities. The authorities in the Department of Health need to establish open and constructive dialogue in order to put this idea into action. Sociopolitical implications would include the controversial issues surrounding affirmative action, the practical implications which will only become transparent in the future. Currently it is clear that staff shortages are impacting on the mental health worker's attitude, productivity, and performance. Ongoing support and professional development should become a priority in the agenda of the Department of Health.

10.2.4.2 Instilling Dignity in the Workplace

Injustices and bullying in the work place is not limited to patients only, but extends to staff, students, and colleagues. Peyton, (2003) points out that when patients perceive that they are victims in a system because they are bullied by staff members they stand to loose their self esteem and their health. The same goes for staff members who perceive themselves to be victims. Patients stand to loose their sanity and staff stand to loose their jobs and careers.

The skills of counselors and psychologists transfer easily into coaches, mentors and mediators. As mentors, counselors are already part of the support system in the hospital.

According to Peyton, (2003) a *systems perspective*, offers a framework for understanding that:

- The hospital does not exist in a vacuum; it is part of and related to the environment;
- The hospital comprises a number of interrelated sub-systems;
- The hospital, to flourish, needs an internal congruency between its sub-systems.

10.2.4.3 Virtue Ethics

Referring again to Bateson (1976) who observed that: "*Those who lack all idea that it is possible to be wrong can learn nothing except know-how*" (p. 26) (Section 9.3.2, Chapter 9), calls to mind the aspects of *Virtue and Psychology* (Cawley III, et al., 2000; Fowers, 2005), and Morality *in health science education* (Prozesky, 2006). A particular set of values needs to be developed in the domains of teaching, training, and in the workplace. The ethical issues that need to be addressed in clinical psychology include the good and evil influences that psychologists may consciously or inadvertently bring into people's lives. For example psychologists should be mindful of using quick-fix techniques and procedures, on naively trusting individuals, who believe in the superiority of other cultures' methods. Accountability of therapists actions also need to be clearly spelled out.

10.2.4.4 Political Will.

The initiative of making accountability a national priority needs to be demonstrated by all leaders, politicians, legislators, and government officials. It is significant to note that the former United Nation's chief Kofi Annan's last major farewell speech as Secretary General, choose the topic of *the need for accountability in U.S. foreign policy* (Time, 2006). The need for leaders and legislators awareness of their accountability needs to be a constant and up front issue. Political will includes addressing current problems, such as *crime* and *normlessness* (Bateman, 2007a; De Ionno & Mokopanele, 2007; Staff Reporters & Reuters, 2006), *corruption* (Da Costa, 2007), *unemployment* and *staff shortages* (Bernstein & Johnston, 2007; Harris, 2007; Nthite & Du Plooy, 2006), *xenophobic violence* (Venter, 2008b), *human trafficking*, and the *AIDS* pandemic, all of which impact on mental health.

10.2.4.5 Funding.

The neglect or lack of focus on basic health care is very costly. For example in the USA, Bergin and Garfield (1994) express a serious and deep concern regarding "…*the underfunding of the evaluation of mental health treatment procedures. Although mental disorders are enormously costly to our society and are pervasive throughout it, the funding allotted for research is quite minor compared with the enormous sums devoted to the natural and biological sciences*" (p. 829).

The prompt and visible efficacy of psychotherapy has a direct impact on the funding of mental health according to Benjamin (1993). Psychotherapy does have demonstrated efficacy, although less dramatic than the biochemical interventions such as antidepressants and antipsychotic and anxiolytic drugs. In the eyes of third party payers research funding goes to the biochemical interventions in the treatment of mental disorders.

Also Yalom's (Branfman, 1996) opinion that psychopharmacology will take over the field of psychotherapy is reflected in his statement "*And I tell myself that I don't want to belong to any more committees or teach anymore, because the field is becoming drugs, pharmacotherapy. The next generation of therapists isn't going to be trained for psychotherapy because the insurance companies aren't going to be paying for it any longer*" (p. 1).

Until practice guidelines put forth by medical schemes, insurance companies, and other relevant organizations, are no longer designed to foster cost control, but rather to serve the best interests of patients, will the funding situation remain inadequate for optimal health care. Health workers are not "…*interchangeable commodities in the marketplace*" (Groopman, 2007, p. 97).

10.2.4.6 Greater Social Awareness.

The continuing acceptance of the role, value, and contribution of psychotherapy and psychotherapists is essential to public awareness and political advocacy. High school and college students, the educated public, public officials, corporate and union leaders, and health policy officials need to become more aware of the role, value, and contribution of psychotherapy, therefore "*…it is essential that psychotherapists remain involved in public policy formation through participation in social advocacy and the political process*" (Vandenbos et al., p. 97).

10.2.4.7 Environmental Health

According to the Bill Of Rights (The Constitution of South Africa, 1998), Environmental Law stipulates that individuals have a right to a clean environment. In the case of hospitals that would include a dagga free environment. As indicated in previous chapters of this thesis, the free availability of dagga in Weskoppies Hospital aggravates and compounds the already existing clinical picture of the patient. Hospital architecture in terms of, ventilation, light, temperature control, adequate space, and adequate toilet and bath-shower facilities, also plays a significant role in the well-being of the patient and in the effectiveness of total patient care and rehabilitation.

10.3 ETHICAL CONSIDERATIONS RELATING TO THE PRESENT STUDY

Ethnography has been an especially suitable methodology in the present study because the *intact* cultural or social group in the hospital was observed over a *prolonged period* of time in which I was is a *participant*. In grappling with the complexity of culture and treatment, I was able to be a natural and accepted participant of all interactions of which I was part, and which I witnessed. As a result I was able to reflect on, understand the intact group of people interacting in a specific place, according to their everyday way of life. From observing and participating in the total culture-sharing group of Weskoppies

Hospital, many observations were made, information gained, and interactions were experienced, with key informants who included staff and patients alike.

Being a participant immersed in the contextual field through a prolonged stay of sixteen years, I was able to gather data from a *range* of sources, and observe and study natural everyday group sharing activities, in everyday contexts, rather than under experimental conditions created by a researcher.

The question of reliability and validity is an issue with qualitative research. However the *trustworthiness* of the researcher's data collection and analysis, replaces the criteria expected from researchers who employ quantitative research designs.

10.4 FUTURE RESEARCH

Within a *qualitative* research design Thomas's (1993) reminder that *critical* ethnographers study culture in order to change it, while *conventional* ethnographers study culture in order to describe it, a more critical ethnographic inquiry may be made. Within a *quantitative* research design, a host of hypotheses may be generated from the contents of this thesis. For example, the implementation of *multiple leadership* may be researched, or a *force field analysis* to establish the facilitating and restraining factors may be carried out. The effectiveness of weekly focused group psychotherapy, in *all* wards may be investigated. Bodemer's (1984) recommendations of a good knowledge of the culture, customs, language, as well as the literature, will help with the diagnosis of depression in Black South Africans, may be further investigated, as well as the need to define criteria as well as reliable rating scales for depression in Black South Africans may be refined.

Finally, there is a need for much more research about the mental health issues and needs of diverse populations in South Africa, into which psychotherapy approaches may be more appropriate and effective for these populations. It is hoped that the present deficiencies will be corrected in the coming decade, and that research will contribute to the development and improvement of South Africa's health status, through prevention

and promotion of healthy life styles, and to constantly improve the health care delivery system by focusing on access, equity, efficiency, quality and sustainability.

I earnestly hope that the commitments renewed or made by all authorities in the course of South Africa’s ongoing transformation, are not mere declarations of good intentions or objectives for which to aspire, but steadfast commitments to uphold, so that our country will be truly fit for humankind, and thus caring for the mentally ill can at last become a reality.

10.5 CONCLUSION

The above recommendations are one way in which psychologists can more effectively influence decision makers in South Africa, to appreciate the cost and therapeutic effectiveness of adopting an ecosystemic, integrative, and interdisciplinary approach to mental health.

Throughout this thesis, I have adequately motivated the importance of creating wholesome therapeutic communities, and the different effective psychotherapeutic approaches to achieve this goal. In conclusion I would like to share the thoughts of Bader and Pearson (2006b), on the real difference between psychological treatment and medical treatment. Psychotherapy is effective with people in everyday walks of life, not only for the mentally ill, as is the case of psychiatric medication. Psychotherapy affords an opportunity into a person’s life experiences. There is no one single solution for the problem of living. Every solution to a complex problem, no matter how perfect, sets the stage for new problems and stresses. If for example you help someone who is shy and withdrawn, s/he will take on challenges s/he has avoided because of the shyness. This can lead to a whole new set of awkward emotions and feelings of insecurity. One problem solved, and another starts. The medical profession doesn't seem to struggle with this issue. A person has malaria of flu, gets treated, and it's over. The problem of living is not neatly diagnosed and treated. Even when therapy works well, it often ends without a noticeable relief or return of energy like the feeling we get when we recover from the flu.

There is no doubt that psychotherapists do help people, but even evidence based research shows that psychotherapy is an inexact profession. What we can achieve is dependant partially on what the client or patient allows us to do and the effort they put into it. In the medical model, the benefits of penicillin or anti-biotics do not depend on the patient's motivation or ability to understand the disease.

Since I have been part of the context in which I have been researching and inquiring into, the process of inquiry reflects my experiences about the psychological treatment and training over the past sixteen years.

Many aspects in this thesis have referred to a global attitude and approach towards mental health, and the appropriate psychotherapeutic approach to deal with the many multicultural aspects related to mental health. In this context one may ask the following questions. How do we conceive the emerging global society? Is our world a house of fear and conflict or a house of healing? Is the encounter with cultural diversity an experience of confusion and conflict or does it open us to a new integrated way of relating to each other? Do we really want to promote a culture that truly responds to all the questions of bringing about healing in humankind?

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Appendix 1

DEPARTEMENT VAN GESONDHEID

DEPARTMENT OF HEALTH

GAUTENG PROVINCIAL HOSPITALS GAUTENG PROVINSIALE HOSPITAL

Weskoppies Hospital
Enquiries: Mrs M A Mabena
11/03/2004

Mr Garfield A Brown Principal
Clinical Psychologist Medunsa
Firm
Weskoppies Hospital

Mr Brown

Your letter dated 05 March 2004 refers.

Permission is hereby granted for Prof J M Nieuwoudt from Unisa to attend Medunsa Firm ward rounds and group therapy sessions in preparation for your enrolment towards the completion of your doctoral studies.

I wish to take this opportunity to wish you well with your studies.

...I:I)J.~~~ ..
M A Mabena
Chief Executive Officer

1892 1992

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