

**THE THERAPEUTIC RELATIONSHIP AS REFLECTED IN THE EXPERIENCES  
OF HOSPITALISED PSYCHIATRIC PATIENTS: AN EXPLORATIVE-  
DESCRIPTIVE STUDY**

Manfred Wilhelm Böhmer

A thesis submitted to the Faculty of Health Sciences, University of Pretoria, in partial  
fulfilment of the requirements for the degree of Doctor of Philosophy

Supervisor: Professor Christa Krüger

Pretoria, 2015

And therefore if the head and body are to be well, you must begin by curing the soul; that is the first thing. And the cure, my dear youth, has to be effected by the use of certain charms, and these charms are fair words; and by them temperance is implanted in the soul, and where temperance is, there health is speedily imparted, not only to the head, but to the whole body.

*The Charmides in the Dialogues of Plato (375 B.C.)*

Da sitzt er, der patiens, der Leidende, dieses erstaunliche und bewundernswerte Wesen, das wie Prometheus an den Felsen seiner Konstitution geschmiedet ist ... wessen er bedarf ist eben nicht nur das Medikament. Er bedarf des Trostes.

*There he sits, the patient, the sufferer, this amazing and admirable creature, who like Prometheus is chained to the rock of his constitution ... what he needs is indeed not only medication. He needs consolation.*

*Ex ovo. Peter Bamm. (1968: 76)*

## DECLARATION

I, Manfred Wilhelm Böhmer, declare that this thesis is my own work. It is submitted to the University of Pretoria for the degree Doctor of Philosophy. It has not been submitted before for any degree at this or any other university.

---

\_\_\_\_\_ day of \_\_\_\_\_ 2015.

## DEDICATION

This thesis is dedicated to all our patients and the health professionals caring for them.

## ACKNOWLEDGEMENTS

I wish to acknowledge and thank the following people. Without their help and support this project would not have been possible.

- Professor Christa Krüger, my supervisor and Head of Research, Department of Psychiatry, University of Pretoria, for her unwavering support in pursuing this research topic, as well as for her continued guidance and advice on this project.
- Professor Willem Schurink, for his support and expert advice on qualitative research, and for the many meetings during which we could discuss the research process and problems encountered.
- Professor Louw Roos, Head, Department of Psychiatry, University of Pretoria, for his ongoing support.
- Mrs Maureen Mabena, for supporting research in the hospital where she is the CEO, and for handling all potentially difficult situations in her calm and composed manner.
- Professor Gerhard Lindeque and the PhD Committee for allowing this research and for granting me sabbatical leave to be able to focus on this study.
- The Research Committee of the Department of Psychiatry for supporting this work financially.
- Mrs Magriet Lee, information specialist at the medical library, for her help with the literature search.
- Mr Stephen James, administrator at the Department of Psychiatry, for administrating the financial aspects and organising the printing.
- Professor Ulrich Schmid (1926 – 2012), Head, Department of Surgery, Kalafong Hospital, University of Pretoria, from 1972 – 1988, for thirty years of mentorship and friendship.
- My wife, Linde, and son, Thomas, for their support.

## **SUMMARY**

### **1. BACKGROUND**

Mental health problems are on the increase, yet mental health care is a low priority worldwide. A recent report on mental health in the USA in 2015 stated that nearly 20 per cent of adults in the USA suffer from mental illness. In South Africa up to 80 per cent of individuals with common mental disorders do not receive treatment. There are also questions about the efficacy of treatment for mental disorders. For example, there is no evidence that treatment outcomes in depression are better than they were a quarter of a century ago. Consistent findings of research indicate, however, that a good therapeutic alliance can improve the outcome of treatment. But do physicians engage with their patients and build good therapeutic relationships? This question is especially pertinent in a psychiatric training institution, such as Weskoppies Hospital, the main psychiatric training hospital of the University of Pretoria. This study was undertaken to explore experiences and therapeutic relationships of patients in Weskoppies Hospital, to develop a model and substantive theory of therapeutic relationships and to comment on registrar training.

### **2. METHODS**

An explorative-descriptive qualitative collective instrumental case study was done. Thirty in-depth semi-structured interviews were conducted with 15 inpatients of Weskoppies Hospital. Purposive sampling was used to ensure maximum variation and richness of information. Transcribed recordings were organised using the computer programme ATLAS.ti. Grounded theory methods were used for the data analysis.

### **3. RESULTS**

Only three patients described a good to very good therapeutic relationship with their registrars. Two other patients, although positive about certain qualities of their registrars, still had reservations about their interactions. Eleven patients had spent lengthy periods in closed wards. None of the three patients who described a good relationship with their

registrars had been subjected to any coercive measures. Registrars rotate four-monthly, most have a symptom-based, biological approach and are used to seeing their patients only once a week due to a high workload. Encounters between staff and patients were mostly superficial; fellow patients became very important to most patients.

The findings point to a lack of containment. Therefore, a model and substantive theory of therapeutic relationships in a psychiatric hospital was developed in which the concept of containment was placed at the centre. Containment should ideally be provided through a personal, professional relationship with the registrar/psychiatrist or with another team member. This, however, needs to be embedded in a containing environment, since whatever happens in a hospital cannot be seen in isolation, but is part of a complex inter-related system and has to be seen from a systems point of view.

#### **4. CONCLUSION**

This model and substantive theory may contribute to a better understanding of the complexity of the situation in a psychiatric hospital. The findings show that a greater focus on therapeutic relationships is needed in the training of registrars. Providing a personal form of containment may lessen the need for coercive measures. Strict guidelines are furthermore needed to limit and control the use of coercive measures.

#### **KEY WORDS:**

Patient experiences, therapeutic relationship, helping alliance, psychiatric care, multi-disciplinary team, containment, registrar training, psychiatric residence, psychotherapy, systems theory.

## GLOSSARY OF TERMS AND ABBREVIATIONS USED

Doc no	Document number: This refers to the number of the interview recorded and transcribed. At the end of each quotation in Section 2 the document number is added in brackets, e.g. P 22:17; this means that the quote is from the 17 <sup>th</sup> line of document number 22.
DSM	Diagnostic and Statistical Manual of Mental Disorders: The classification system of mental illness developed by the American Psychiatric Association.
ECT	Electroconvulsive therapy
HoD	Head of Department
I	Interviewer
Intern	Used in the medical field to describe a recently qualified medical doctor who has to work for two years in an accredited hospital under supervision before being allowed to practice on his/her own
Intern psychologist	A recently qualified psychologist who has to work for one year in an accredited psychiatric hospital under supervision before being allowed to practice on his/her own
MDT	Multi-disciplinary team
OT	Occupational therapist
P	Patient
prn	Pro re nata (if required)
Pt no	Patient number
Registrar	A qualified medical doctor specialising in a field of medicine, e.g.

psychiatry (called a resident in the USA)

UP

University of Pretoria

WKH

Weskoppies Hospital

## TABLE OF CONTENTS

DECLARATION .....	iii
DEDICATION.....	iv
ACKNOWLEDGEMENTS .....	v
SUMMARY .....	VI
1. Background.....	vi
2. Methods.....	vi
3. Results.....	vi
4. Conclusion .....	vii
Key words:.....	vii
GLOSSARY OF TERMS AND ABBREVIATIONS USED .....	VIII
TABLE OF CONTENTS .....	X
LIST OF TABLES.....	XXI
LIST OF FIGURES .....	XXI
SECTION 1 THE STUDY AND ITS METHODOLOGY .....	1
1 CONTEXTUALISING THE STUDY .....	2
1.1 Introduction and background.....	2
1.2 Training of registrars .....	4
1.3 Problem statement and research question .....	9
1.4 Aims and objectives .....	11
1.4.1 Aims .....	11

1.4.2 Objectives.....	11
1.5 Personal interest .....	12
1.6 My different roles in the hospital.....	14
1.7 Anticipated contributions .....	14
1.7.1 Theoretical contributions.....	14
1.7.2 Methodological contributions .....	15
1.7.3 Practical contributions.....	15
1.8 Existing knowledge.....	16
1.9 Thesis structure.....	17
2 RESEARCH APPROACH AND ITS IMPLEMENTATION .....	19
2.1 Introduction .....	19
2.2 Qualitative research as research approach .....	19
2.3 My research philosophy .....	21
2.4 The place of literature in qualitative research and the relation between theory and research	23
2.5 The process of coding and different ways of data analysis in the development of theory .....	26
2.6 Research ethics .....	30
2.7 Qualitative research design.....	31
2.8 Research methodology .....	33
2.8.1 Study setting.....	34
2.8.2 Study population and sampling.....	35
2.8.3 Sample size and data saturation.....	37
2.8.4 Collection and recording of data .....	39
2.8.5 Data management.....	42
2.8.6 Data analysis and synthesis as a cyclical process .....	43
2.8.7 Representing the data: writing up .....	45
2.9 Strategies to ensure quality.....	46

2.10	Summary of Chapter 2 .....	50
SECTION 2 THE FINDINGS .....		51
3	INTRODUCTION TO THE FINDINGS .....	52
3.1	Admission to Weskoppies Hospital.....	52
3.2	The participants.....	55
3.2.1	Brief clinical summary of research participants .....	55
3.2.2	Profile of the research participants.....	57
3.2.3	Summary of the interviews and patients .....	63
3.2.4	Summary of the distribution of patients in terms of race and gender.....	65
3.3	Making sense of the data: the development of models of containment and therapeutic relationships.....	65
3.3.1	First model: Important relationships in a psychiatric hospital .....	66
3.3.2	Second model of important relationships in a psychiatric hospital.....	67
3.3.3	Third model: A setting emerges .....	68
3.3.4	Fourth model: The concept of containment is introduced.....	69
3.3.5	Fifth model: A different way of seeing the setting.....	71
3.3.6	Sixth model: The hospital as community.....	72
3.3.7	Seventh model: The final model of therapeutic relationships .....	74
3.4	Summary of Chapter 3 .....	76
4	THE HOSPITALISATION PROCESS AND INITIAL EXPERIENCES.....	78
4.1	Central Admissions .....	78
4.2	Hospital environment.....	79
4.3	Admission to different teams .....	80
4.4	Open wards.....	80
4.5	Closed wards .....	81
4.5.1	Introduction.....	81
4.5.2	Daily routine in the closed wards and being locked into the dormitories.....	82

4.5.3	Feeling helpless.....	85
4.5.4	Forced treatment .....	87
4.5.5	The transfer to an open ward.....	88
4.6	Sexual needs linked to loneliness.....	89
4.7	Ethical violations .....	89
4.8	Other comments.....	91
4.9	Summary of Chapter 4 .....	92
5	HOLDING AND CONTAINMENT - OR THE LACK THEREOF: THE PRIMARY FACTORS .	93
5.1	Nursing staff.....	94
5.1.1	Positive experiences with nursing staff .....	94
5.1.1.1	Attitudes and attributes .....	94
5.1.1.2	The importance of nursing staff.....	98
5.1.1.3	But things can go wrong .....	100
5.1.1.4	Burnout? The positive experience with trainee staff .....	101
5.1.1.5	Negative experiences with nursing staff.....	102
5.1.2	Negative experiences with nursing staff.....	102
5.1.2.1	Experiences with nursing staff in closed wards .....	102
5.1.2.2	Everything that you say is written down (observations).....	104
5.1.2.3	Conflict in the ward between staff and patients .....	104
5.1.2.4	A reactionary attitude with lack of containment .....	105
5.2	Registrars.....	105
5.2.1	Positive experiences with registrars.....	106
5.2.1.1	Registrars are important .....	106
5.2.1.2	Belief in the doctor .....	107
5.2.1.3	Attributes of doctors who become important to their patients .....	107
5.2.2	Differences between registrars .....	111
5.2.3	Some further comments on the role of the doctor .....	114
5.2.4	Negative experiences with registrars .....	114
5.2.4.1	Consultations once a week .....	114
5.2.4.2	And then mostly short symptom orientated consultations.....	115
5.2.4.3	Other factors that impair the development of a therapeutic relationship .....	117

5.3	The rest of the multi-disciplinary team (MDT) .....	124
5.3.1	General comments about the team.....	124
5.3.2	Psychologists .....	127
5.3.3	Occupational therapists .....	130
5.3.4	Social workers .....	131
5.3.5	The pastoral counsellor .....	133
5.3.6	Other members.....	133
5.4	Other people involved .....	135
5.4.1	Fellow patients .....	135
5.4.2	Other staff: Cleaners .....	140
5.4.3	Medical students.....	141
5.5	Studying of hospital files.....	142
5.6	Summary of Chapter 5 .....	144
6	HOLDING AND CONTAINMENT - OR THE LACK THEREOF: THE SECONDARY FACTORS.....	146
6.1	Religion, spirituality, culture and language.....	146
6.1.1	Religion and spirituality.....	146
6.1.2	Culture and language .....	150
6.2	Family and friends.....	151
6.3	Summary of Chapter 6 .....	152
7	THE THERAPEUTIC RELATIONSHIP: A POSSIBILITY AWAITING REALISATION .....	154
7.1	Is a therapeutic relationship important to patients and why?.....	154
7.2	Factors that influence the development of a therapeutic relationship.....	156
7.2.1	Aspects around time, frequency of being seen and boundaries .....	156
7.2.1.1	Seen soon after admission and informed about program .....	156
7.2.1.2	Frequency of being seen.....	157
7.2.1.3	Addressing unrealistic expectations .....	157
7.2.1.4	Having time.....	158
7.2.1.5	Boundaries .....	160

7.2.2	Short rotations .....	160
7.2.3	Attitude .....	161
7.2.3.1	Being interested in the patient.....	161
7.2.3.2	Listening .....	161
7.2.3.3	Creating an atmosphere of acceptance, trust and safety.....	162
7.2.3.4	Collaboration.....	163
7.2.3.5	Giving positive feedback .....	164
7.2.3.6	Being available and easy to reach .....	164
7.2.3.7	Keeping promises .....	164
7.2.3.8	Understanding the fears of the patient .....	165
7.2.3.9	Overcoming resistances .....	165
7.2.4	The therapeutic relationship and the team .....	166
7.2.5	Psycho-education .....	167
7.2.6	Seeing the registrar with students present.....	167
7.2.7	Other important factors .....	168
7.3	Does a therapeutic relationship need a long time to develop? .....	168
7.4	What is possible in challenging circumstances? .....	170
7.5	Summary of Chapter 7 .....	170
SECTION 3 TOWARDS A MODEL OF THERAPEUTIC RELATIONSHIPS IN A PSYCHIATRIC HOSPITAL .....		172
8	LITERATURE REVIEW .....	173
A summary of the literature review .....		173
8.1	Mental health care: The ideal .....	176
8.1.1	What is a hospital supposed to be? .....	176
8.1.2	What is mental health? .....	177
8.2	Mental health care: The reality .....	178
8.2.1	Difficult feelings and what to do with them .....	178
8.2.2	Difficult experiences around time .....	180
8.2.3	Difficult experiences in closed wards: forced medication, seclusion and other measures of containment.....	181

8.2.4	Difficult experiences around non-adherence or non-compliance.....	188
8.2.5	Problems in the practice of nursing.....	189
8.2.6	Complaints by patients .....	191
8.3	Models of mental health care .....	192
8.3.1	The present dominant model or paradigm in medicine.....	192
8.3.2	A systems approach .....	198
8.3.3	The wish and need for person-centred care.....	202
8.3.4	Research on patients' experiences and their opinions about what constitutes good care .. .....	207
8.4	Central aspects of relationships.....	211
8.4.1	Existence as “being-in-a-relationship” .....	211
8.4.2	Mirror neurons .....	212
8.4.3	Attachment .....	213
8.4.4	Empathy .....	216
8.4.5	Language .....	221
8.4.6	Verbal and non-verbal behaviour.....	223
8.4.7	Holding, containment, or keeping someone in mind: a psychoanalytic perspective.....	224
8.4.8	From holding to being remembered and the continuity of life .....	229
8.5	The therapeutic alliance .....	230
8.5.1	Definitions and descriptions.....	231
8.5.2	Why does it matter?.....	231
8.5.3	Trust.....	234
8.5.4	The particular <i>place</i> of therapy or consultations.....	235
8.5.5	Social class .....	236
8.5.6	Different models of interacting with patients.....	237
8.5.7	The intercultural and interracial therapeutic relationship .....	238
8.5.8	First consultation and frequency of being seen: comments from a psychoanalytic point of view .....	241
8.6	Training of psychiatric registrars.....	242
8.6.1	Some general comments on training .....	242
8.6.2	Mentoring needs.....	244
8.6.3	Balint groups .....	244

8.6.4	What attention should the registrar's personal characteristics and mental health receive?	246
8.6.5	What needs attention? A few central aspects	250
8.6.5.1	Being present, listening, explaining	250
8.6.5.2	Reflecting on the treatment facility	252
8.6.5.3	Including psychoanalytic concepts, skill and attitudes in teaching	253
8.6.5.4	The need for on-going professional development	255
8.7	Linking the literature review with the rest of the study	256
9	AN ANALYSIS OF THE CARE AND TREATMENT OFFERED AT WESKOPPIES PSYCHIATRIC HOSPITAL, LEADING TO THE DEVELOPMENT OF A MODEL AND SUBSTANTIVE THEORY OF THERAPEUTIC RELATIONSHIPS	257
9.1	Introduction	257
9.2	Encounters in the hospital	261
9.2.1	Superficial encounters	261
9.2.2	Negative encounters	264
9.2.3	Meaningful encounters	268
9.2.3.1	Seemingly superficial encounters that can be meaningful	268
9.2.3.2	Encounters with religion, spirituality, culture and language	271
9.2.3.3	Meaningful deep encounters	272
9.2.4	Reflections on encounters	273
9.3	Containment	277
9.4	The multi-disciplinary team	282
9.5	The seventh model: A model and substantive theory of therapeutic relationships	284
9.5.1	The frame, including the treatment paradigm	286
9.5.2	The inner circle	287
9.5.2.1	The patient and the MDT	287
9.5.2.2	Management: the fourth semicircle	288
9.5.2.3	Illustrations of the containing function, or lack thereof, of the 'inner circle'	288
9.5.3	Outside the inner circle but still inside the wall	290
9.5.4	Outside the wall	291
9.5.4.1	The community, family and friends	291

9.5.4.2	Religion, spirituality, culture and language .....	291
9.5.4.3	The socio-economic and political situation .....	291
9.5.5	The red bar – the therapeutic relationship.....	292
9.5.6	Wrapping up the seventh model and substantive theory of therapeutic relationships...	292
9.6	Obstacles in the realisation of a therapeutic relationship .....	294
9.6.1	Superficial encounters .....	295
9.6.2	Negative encounters.....	296
9.6.3	Splitting of the bio-psycho-socio-spiritual approach .....	297
9.7	How common is a therapeutic relationship? .....	298
9.8	Some concluding remarks on the model and substantive theory of therapeutic relationships....	298
9.9	Summary of Chapter 9 .....	300
10	AN ANALYSIS OF THE TRUSTWORTHINESS OR ‘GOODNESS’ OF THE STUDY .....	301
10.1	Concerns about case study and insider research .....	301
10.2	The trustworthiness or ‘goodness’ of the study .....	302
10.2.1	Reflexivity .....	303
10.2.2	Audit trail.....	304
10.2.3	Triangulation or crystallisation.....	305
10.2.4	Peer reviewing.....	308
10.2.5	Thick descriptions.....	309
10.2.6	Member validation .....	309
10.3	Summary of Chapter 10 .....	309
SECTION 4.....		310
CONCLUDING NOTES.....		310
11	SUMMARY, IMPLICATIONS AND RECOMMENDATIONS.....	311
11.1	Introduction .....	311

11.2	A summary of the study and the findings .....	311
11.3	Ethical problems flowing from the study.....	314
11.4	Key contributions and implications.....	316
11.4.1	Theoretical contributions.....	317
11.4.1.1	A model and substantive theory of therapeutic relationships.....	317
11.4.1.2	Containment as key concept.....	317
11.4.1.3	Shortcomings in the training of registrars.....	318
11.4.1.4	Three strategies for ensuring quality and trustworthiness in qualitative studies....	319
11.4.2	Methodological contributions .....	319
11.4.2.1	Qualitative research.....	319
11.4.2.2	Combining a case study approach with methods of analysis stemming from grounded theory.....	320
11.4.3	Practical contribution or value of the study.....	320
11.4.4	Summary of contributions .....	322
11.5	Recommendations .....	323
11.5.1	Recommendations to provincial management .....	323
11.5.2	Recommendations to hospital management .....	323
11.5.3	Recommendations to the Department of Psychiatry, UP, and the College of Psychiatrists of the CMSA, South Africa .....	324
11.5.5	Concrete suggestions specific to the situation in WKH.....	326
11.5.5.1	General recommendations about the interaction between registrars and patients.. .....	326
11.5.5.2	Registrar allocations to the teams and allocations of wards .....	327
11.5.5.3	The academic programme .....	327
11.5.5.4	The out-patient clinics .....	327
11.5.5.5	Ward programme.....	328
11.5.6	The role of the consultants.....	328
11.6	A final assessment of the situation in WKH .....	329
11.7	Limitations and future research .....	329
12	PERSONAL REFLECTIONS.....	331
	REFERENCES .....	334

APPENDICES.....	370
Appendix A: Letters of approval .....	371
Appendix B: Patient information leaflet and consent form .....	373
Appendix C: Patient questionnaire .....	376

## LIST OF TABLES

TABLE 1:	OVERVIEW OF THE STRUCTURE OF THE FOUR-YEAR TRAINING PROGRAMME .....	6
TABLE 2:	WEEKLY ACADEMIC ACTIVITIES .....	7
TABLE 3:	WEEKLY PROGRAMME OF THE REGISTRARS WORKING IN THE FRIDAY TEAM.....	8
TABLE 4:	THE STRUCTURED WEEKLY PROGRAMME OF THE FRIDAY TEAM'S REGISTRARS, ACADEMIC ACTIVITIES INCLUDED .....	54
TABLE 5:	BRIEF CLINICAL SUMMARY OF RESEARCH PARTICIPANTS .....	55
TABLE 6:	DISTRIBUTION OF PATIENTS IN TERMS OF RACE AND GENDER.....	65
TABLE 7:	DESCRIPTION OF CONTAINMENT MEASURES.....	182
TABLE 8:	DIFFERENCES BETWEEN THE BIO-MEDICAL AND PERSON-CENTRED MODEL OF MEDICINE .....	205
TABLE 9:	SUMMARY OF THE MOST SALIENT FINDINGS WITH EACH PARTICIPANT .....	258

## LIST OF FIGURES

FIGURE 1:	THE FIRST MODEL OF IMPORTANT RELATIONSHIPS IN A PSYCHIATRIC HOSPITAL.....	66
FIGURE 2:	THE SECOND MODEL OF IMPORTANT RELATIONSHIPS IN A PSYCHIATRIC HOSPITAL.....	67
FIGURE 3:	THE THIRD MODEL: A SETTING EMERGES.....	68
FIGURE 4:	THE CONCEPT OF CONTAINMENT IS INTRODUCED.....	70
FIGURE 5:	FIFTH MODEL: A DIFFERENT WAY OF SEEING THE SETTING.....	71
FIGURE 6:	THE SIXTH MODEL: THE HOSPITAL AS COMMUNITY.....	73
FIGURE 7:	THE SEVENTH MODEL: THE FINAL MODEL OF THERAPEUTIC RELATIONSHIPS .....	75
FIGURE 8:	THE INTER-RELATIONSHIP OF THE LITERATURE REVIEW .....	175
FIGURE 9:	GUY DE PARC, FIGURE D'ANATOMIE, CHANTILLY, MUSÉE DE CONDI (ROMANYSHYN 1989: 121) .....	194
FIGURE 10:	ANDREAS VESALIUS DEMONSTRATING A DISSECTED ARM, WOODCUT BY JOHANN STEPHAN VON CALCAR (ROMANYSHYN 1989: 120).....	195
FIGURE 11:	HIERARCHY OF NATURAL SYSTEMS (ENGEL 1980: 537).....	197
FIGURE 12:	THE SEVENTH MODEL: A MODEL AND SUBSTANTIVE THEORY OF THERAPEUTIC RELATIONSHIPS .....	285
FIGURE 13:	LACK OF CONTAINMENT.....	289
FIGURE 14:	CONTAINMENT PROVIDED .....	290

## **SECTION 1**

# **THE STUDY AND ITS METHODOLOGY**

**In this section:**

**Chapter 1: Contextualising the study**

**Chapter 2: Research approach and methodology**

# 1 CONTEXTUALISING THE STUDY

## 1.1 INTRODUCTION AND BACKGROUND

Mental health problems are on the increase worldwide; more and more people are in need of help. A recent report on the mental health in the USA in 2015 stated that 42.5 million (18.19 per cent) of adults in America suffer from mental illness, 19.7 million (8.46 per cent) suffer from a substance use problem and 8.8 million (3.77 per cent) report serious thoughts of suicide. Only 41 per cent of individuals with mental illness reported receiving treatment (Mental Health America 2015).

In South Africa the situation is much worse. The severe shortage of psychiatrists and lack of as well as neglect of psychiatric facilities, hinder the treatment of those in need (Burns 2010; Gillis 2012). The headline on the front page of the Sunday Times, the biggest newspaper in South Africa (SouthAfrica.info 2013) on July 6, 2014, read: “SA’s sick state of mental health”. The Sunday Times claimed that one third of South Africa’s population suffers from mental illness and that 75 per cent of these will not receive treatment. (This was already the finding of Seedat et al. in 2008 – see below.) It further described the dire state of South Africa’s health facilities and the prison-like conditions in these facilities.

In spite of the increase in problems, mental health care is a low priority worldwide, receiving stunted budgets, inadequate resources and little attention from governments. The discrepancy between mental health needs and mental health service provision is, however, more extreme in low- and middle-income countries, especially in Africa (Burns 2010). Burns, present Head of the Department of Psychiatry at the University of KwaZulu-Natal, describes the poor state of mental health care in South Africa as follows:

Despite South Africa's progressive mental health legislation (Mental Health Care Act, 2002), the same barriers to the financing and development of mental health services exist, which result in: (i) psychiatric hospitals remaining out-dated, falling into disrepair, and often unfit for human use; (ii) serious shortages of mental health professionals; (iii) inability to develop vitally important tertiary level psychiatric services (such as child and

adolescent services, psychogeriatric services, neuropsychiatric services, etc.); and (iv) community mental health and psychosocial rehabilitation services remaining undeveloped (Burns 2010).

Burns states that “(t)he mean increase in budget allocations to public psychiatric hospitals was 3.8 per cent per annum, while that to general hospitals over the same period was 10.2 per cent per annum.” (The period he refers to are the years 2005/2006 – 2009/2010.)

He also notes that there are in KwaZulu-Natal only 0.38 psychiatrists per 100 000 population in the public sector and that, of the nine provinces, only the Western Cape and Gauteng have a better ratio of psychiatrists to population. Another upsetting statistic is that 75 per cent - 80 per cent of individuals with common mental disorders in South Africa do not receive any treatment (Seedat et al. 2008; Burns 2014).

Since my appointment by the University of Pretoria in 2010, I have been wondering how this situation affected the training of registrars in psychiatry. How do they balance patient-care with training requirements? How does a very high workload affect their training? Where does person-centred care or psychotherapy feature in such a situation? Does it feature at all? Other important questions are: What do patients experience, and how does nursing staff cope in such difficult circumstances?

The problem is compounded by questions about the efficacy of treatment for mental disorders. For example, Mintz and Flynn (2012) write that despite safer and more tolerable antidepressant treatment, there is no evidence that treatment outcomes are better than they were a quarter of a century ago.

Whilst writing this, I received a notice on my computer from the American website Medscape about an article published online ahead of print in the *British Journal of Psychiatry* by Leuchter et al. (2014). The researchers observed that the strength of the therapeutic alliance with research personnel was significantly associated with clinical outcomes, whether patients were on medication or placebo.

"Good, compassionate care, connecting with your patients, letting them know that you want them to do well, that you are strongly bonded with them, that is all part of the art of medicine", Dr. Leuchter told *Medscape Medical News*. Leuchter ended the interview with

the statement: "And I hope that this message is going to (be) a major take-home from this study — that patients get well in good measure because they connect with those who are providing care for them" (Harrison 2014).

Patients suffer from their illnesses and suffer because of the system, but there is one factor that does not cost anything and that can make a difference: the therapeutic relationship. More and more publications emphasise the importance of this alliance, not only for alleviating the loneliness of the psychiatric patient, but also for improving the outcome of treatment.

What is possible in our situation? Do our registrars connect with their patients? Do they focus on establishing a therapeutic relationship? Or are they overworked and only pill-pushers?

At this stage, I need to give an overview of the present training programme of registrars in the Department of Psychiatry, University of Pretoria.

## **1.2 TRAINING OF REGISTRARS**

It takes four years of post-graduate training to become a psychiatrist in South Africa. After completion of their undergraduate studies, physicians first have to work for two years under supervision, followed by a year of community service, before they can apply for a post as a registrar at one of the eight universities in South Africa that have medical schools. Many candidates first work as general medical practitioners before deciding on further training. Most registrars are thus in their late twenties or early thirties when they start their specialisation.

The four years of training are very structured. Several hospitals are part of the training circuit of the University of Pretoria; these include Weskoppies Psychiatric Hospital (the main training hospital), acute assessment and inpatient units at Steve Biko Academic Hospital, as well as Emalahleni Hospital, and also Community Psychiatric Services in the Tshwane area. In Weskoppies Psychiatric Hospital (WKH) registrars rotate on a four-monthly basis between the different teams to get exposure and training in adult psychiatry,

child and adolescent psychiatry, forensic psychiatry and outpatient clinics. They also have to work for four months in the Department of Neurology at the Steve Biko Pretoria Academic Hospital, at the end of which they have to pass a clinical examination in neurology. In the first two years, they have to pass examinations in four primary subjects; these are neuro-anatomy, neuro-physiology, neuro-pathology and medically applied psychology. A research project also has to be completed; this starts with training in basic research methodology, then a supervisor is allocated to them, and they have to embark on a research project leading to a publication in an accredited journal. As part of their psychotherapy training, they have to complete three psychotherapies under strict supervision.

Their week is also well structured with many diverse academic activities, such as discussions and lectures in general psychiatry, neuro-psychiatry, psychotherapy, forensic psychiatry, a weekly journal club and two ward conferences per team per week, in each of which a patient is presented and discussed in depth.

In their fourth year, if their specific universities state that they have fulfilled all the necessary requirements of the training programme, they are allowed to sit for the final examination held by the College of Psychiatrists of the Colleges of Medicine of South Africa. The College is the only exit examination body since 2014 / 2015. The requirements for this final examination include passing the primary examinations already mentioned, and having had satisfactory supervised experience and training in the fields of neuropsychiatry, psychotherapy, emergency and crisis care, the care of the geriatric patients, alcohol and substance abuse / dependence, mental handicap and forensic psychiatry. Psychotherapy training covers the theoretical aspects of cognitive-behavioural therapy (CBT), psychodynamic psychotherapy, family therapy, supportive therapy and group therapy. Trainees need also to complete three therapies from a CBT or supportive framework under supervision; working from other orientations, e.g. psychodynamic psychotherapy or group psychotherapy, is optional. (The requirements for training can be found at [http://www.collegemedsa.ac.za/view\\_exam.aspx?examid=41](http://www.collegemedsa.ac.za/view_exam.aspx?examid=41).)

If they pass this national examination, they are awarded the Fellowship of the Colleges of Medicine, the FC Psych (SA) qualification. On completion of their research project, leading to either a publication in a peer-reviewed journal or a dissertation, they are also awarded

the MMed Psych qualification (Master of Medicine in Psychiatry) at the University of Pretoria.

An overview of the structure of the four-year training programme at the Department of Psychiatry, University of Pretoria, is given in Table 1.

**Table 1 Overview of the structure of the four-year training programme**

Semester	1	2	3	4	5	6	7	8
<b>Examinations</b>	Anatomy	Physiology	Pathology	Psychology	Neurology rotation			FC Psych
<b>Psychology course</b>		x	x					
<b>Psychotherapy theory</b>	x	x	x	x				
<b>Forensic psychiatry</b>	x	x	x	x				
<b>Research / TNM course</b>	TNM course	x	x	x	x	x		
<b>Post-graduate discussions</b>		x		x		x		x
<b>Academic discussions HoD</b>					x	x	x	x
<b>Neuropsychiatry</b>					x	x	x	x
<b>Hours</b>	7	7	7	7	4	5	5	5

## Explanation of course and of abbreviations used

- TNM: A compulsory course in basic research methodology that all students have to attend before embarking on their research project.
- Academic discussions HoD: Academic discussion with the Head of Department, held weekly.
- Neuropsychiatry: A weekly lecture.
- FC Psych: The final examination of the College of Medicines, South Africa, in the field of psychiatry. The candidates have to pass the four primary examinations, as well as an examination in neurology at the end of their four-month rotation there, before they are allowed to sit for the final examination.
- Every registrar has to do an annual post-graduate discussion; these have become more and more elaborate over the years, with some talks given reaching 50 - 55 typed pages.
- Hours: Approximate hours per week of academic activities; the time for the weekly journal club is included.

## Weekly academic activities

If all of the academic activities were transposed onto a weekly roster, it would look as described in Table 2.

**Table 2: Weekly departmental academic activities**

<b>Mo</b>				<b>13h00 - 16h00</b> Psychotherapy and basic skills training
<b>Tue</b>				
<b>Wed</b>			<b>12h00 - 13h00</b> Journal club	<b>13h30 - 14h30</b> Neuropsychiatry

<b>Thu</b>				<b>13h00 - 16h00</b> Academic meeting with HoD
<b>Fri</b>	<b>8h30 - 10h30</b> Forensic psych	<b>10h30 - 11h30</b> Physiology	<b>11h30 - 12h30</b> Post-grad lecture	<b>13h00 - 14h30</b> Psychology

Obviously, registrars will not participate in all of these activities at the same time. For example, only the junior registrars who still have to write the primary examinations will attend the physiology and psychology lectures. Furthermore, if a registrar is on call every Friday he or she will not be able to attend the Friday activities for the four-month period that they are working in the Friday Team.<sup>1</sup>

I drew up the roster of all the weekly academic activities to give an indication of the hours of training, which are quite extensive. Added to this are the weekly activities of each team. As an example, the weekly programme of the registrars working in the Friday Team is as described in Table 3 (academic activities not included).

**Table 3: Weekly programme of the registrars working in the Friday team**

<b>Monday</b>	8h30 - 11h00 MDT meeting
<b>Tuesday</b>	8h30 - 11h00 Ward conference
<b>Wednesday</b>	8h30 - 11h00 Ward conference
<b>Thursday</b>	8h00 -15h30 Out-patients
<b>Friday</b>	On call the whole day All new admissions plus handling of emergencies in WKH.

<sup>1</sup> More information about the different teams working in WKH is given in Section 3.1. Here I just want to add that the old names for the teams, which are still commonly used, were according to the day of the week that they were on call.

The open spaces represent the time available for seeing inpatients (up to 25 or at times even 35 patients per registrar), as well as attending as much as possible of the academic programme. The more senior registrars usually work in the Friday Team, and they would typically attend the Wednesday and Thursday afternoon academic activities, which leave only Monday and Tuesday from 11h30 onwards for their inpatients. (Lunch for the patients is from 12h00 – 13h00.) It is challenging for the registrars to see up to 30 or more patients each during these two afternoons.

I want to highlight some of my impressions about their programme:

- The academic programme, research project included, is of a high standard.
- The presentations done of patients at the ward conferences are also usually of a very high standard. (I had registrars who told me that it took them up to seven hours to prepare a patient for a ward conference; this includes the time spent with the patient.)
- Little time is left for regular consultations of patients. Most inpatients are only seen once a week by their registrar.

I cannot help but empathise with them on their four years of training – it is definitely not easy. Considering this, do our registrars still have the time and energy to focus on therapeutic relationships and to reflect on the importance of this?

### **1.3 PROBLEM STATEMENT AND RESEARCH QUESTION**

After many years of working in psychiatry, my impression is that most psychiatrists focus on biological aspects of psychiatry. This impression is strengthened by my experiences in an academic training hospital where I have worked for the last five years. For various reasons most registrars seem to ‘manage’ their patients. By ‘manage’ I mean that treatment is not embedded in a therapeutic relationship. The patient is rather ‘a someone’ for whom pharmacological treatment is prescribed based on his or her symptoms. A reductionistic approach is followed.

My impressions are echoed by psychiatrists worldwide. A few examples are:

- Gabbard and Kay (2001) voice their concern about proposals in American psychiatry which explicitly call for a dramatic reduction in the provision of psychotherapy by psychiatrists. Under these proposals, they write, psychiatry would be reshaped in a biologically reductionistic direction.
- Research in biological and pharmacological approaches receives far more funding than psychosocial approaches and also more attention in terms of publications and practice (Soldani, Ghaemi and Baldessarini 2005; Ghaemi 2006).
- An editorial in the September 27, 2012 issue of Nature, a leading basic science journal, described it as a scandal that money spent on psychotherapy research is tiny by comparison with the budget for research on pharmacotherapy.
- In their research Mojtabai and Olfson (2008) found a significant decline in the provision of psychotherapy by psychiatrists in the United States in the years 1996 – 2005.

Psychotherapy is not only about seeing a patient for psychotherapy according to a specific school of thought, e.g. cognitive-behaviour therapy or psychodynamic psychotherapy. It is especially about attending to the patient as person.

In his lecture to the American Psychiatric Association in 1986, Reiser said that most residents (*registrars are called residents in the USA*) would learn more about a stranger who was sitting next to them for an hour on an airplane trip than they would learn about a patient in formal psychiatric interviews (Reiser 1988). He criticised an approach where the focus is on eliciting symptoms to then be able to make a diagnosis according to the DSM and not being curious about the patient as person. The patient becomes an object, a thing.

How do patients experience this? How does it affect their treatment and the outcome? What are the unmet needs of patients? What implications do these problems have for the training of psychiatry registrars?

Thinking about this situation led to the following research question: How can we as scholars explore and describe the experiences and views of patients - including the role of a therapeutic relationship - so as to develop a model of therapeutic relationships in a psychiatric hospital?

## 1.4 AIMS AND OBJECTIVES

### 1.4.1 Aims

The aims of this collective instrumental case study of adult patients admitted to WKH are as follows:

- a. To explore what different types of experiences patients have during admission to WKH, which of these are helpful and meaningful, and which experiences are of a negative and perhaps even destructive nature.
- b. To explore the concept of a therapeutic relationship and with which member of the multidisciplinary team (MDT) such a relationship develops: registrar, psychologist, occupational therapist, social worker, nurse or pastor? Or rather with a fellow patient?
- c. To develop a model of therapeutic relationships leading to the development of a substantive theory of therapeutic relationships.
- d. To develop recommendations about training of registrars and service delivery.

### 1.4.2 Objectives

The steps taken to reach the aims were:

- a. An empirical study of the world of the hospitalised psychiatric patient, of their experiences, as delineated in the research design. This will be compared to findings of an in-depth literature research on experiences of psychiatric patients, their needs and wishes, as well as on person-centred care.
- b. An empirical study of the therapeutic relationships that develop between patients and members of the MDT, of the quality and type of this relationship from the patients' perspective. An in-depth literature research will also be done on therapeutic relationships, to be able to better understand the situation in our hospital.
- c. An empirical study to understand what factors influences the interaction between registrar and patient; part of this will be an effort to understand how the hospital as system influences this therapeutic relationship between registrar and patient.

- d. This understanding will be used to develop a model of therapeutic relationships in a psychiatric hospital and to then develop recommendations on registrar training and service delivery.

## 1.5 PERSONAL INTEREST

My personal interest in this research is linked to the 30 years that I have worked in psychiatry. During my years of training as a registrar I was more interested in clinical work. After obtaining my degree I left for private practice to focus on my interest, namely psychotherapy. There a very harsh reality struck me: I had no idea whatsoever of how to conduct psychotherapy. (In spite of having done very well in the psychology course and examination.) In those years, training in psychotherapy did not receive much attention. Furthermore, WKH had at that stage about 1500 patients, three times as many as it does currently, and my time to conduct psychotherapy had been extremely limited. I realised that I had lived under the illusion of being able to conduct psychotherapy and this awakening came as quite a shock.

That was in 1992. Since then I have made many efforts to learn more about psychotherapy. This learning process included my own training-psychotherapy, supervision, being a member of reading groups and attending numerous workshops with local and overseas psychotherapists and psychoanalysts.

After six years in private practice I took up an appointment with the University of Pretoria to help develop psychiatric services and training in Mpumalanga, the province to the East of Gauteng in which, at that stage, there were only two psychiatrists, one of them working in private practice. Four years later I had helped to establish a training facility in Emalahleni, previously called Witbank, and outreach services to several peripheral hospitals in Mpumalanga. I then went back to private practice for another eight years.

Since 2010, I am again in a full-time post with the University of Pretoria, this time stationed in WKH, the main psychiatric training hospital. I am also in charge of the psychotherapy training of the registrars, which, in our South African circumstances, is quite a challenge. Being focussed on a person-centred approach myself, I often wondered what the registrars *really* practice in the wards with their patients. Are they focussed on the patient

or the symptoms? Are they interested in building a therapeutic alliance? Do they use whatever they (hopefully) have learned in the psychotherapy training?

I discovered qualitative research when Professor Christa Krüger, our Head of Research, organised two workshops on qualitative research early in 2013 with Professor Willem Schurink, a well-known local expert qualitative researcher. After having attended these workshops, I realised the potential for qualitative research in WKH on a topic that had interested and bothered me for some time. After several discussions with my supervisor, Professor Krüger and Professor Schurink, I embarked on this project.

I enjoy writing and here was a project where I could link this with a meaningful topic: Do the registrars form therapeutic relationships with their patients? Is our training addressing this aspect of medical care, a topic gaining more and more prominence in the medical literature? Or do they follow the trend of short symptom-focussed consultations? And what do the patients experience in our hospital? What are their needs? Creswell (2013) states that qualitative research is done because a problem needs to be further explored, for example to reach a complex, detailed understanding of an issue, or to hear silenced voices, such as those of patients'.

Qualitative studies are a suitable way of exploring this. According to the literature, there is a lack of such studies, especially by psychiatrists. One of the qualitative studies quoted in the literature research was for example done by a psychologist and an occupational therapist (Johansson and Eklund 2003) and the others by departments of nursing (e.g. Bruster et al. 1994; Barker et al. 1996; Coulter and Cleary 2001; Fitzpatrick 2002). Psychiatric research tends to focus on quantitative studies (Priebe and Gruyters 1995; Krupnick et al. 1996; Müller and Poggenpoel 1996; Barker and Orrell 1999; Howard et al. 2001; Røssberg et al. 2006), which limits understanding of the inner world of the patient, an understanding necessary in establishing therapeutic alliances, crucial to treatment outcomes.

## 1.6 MY DIFFERENT ROLES IN THE HOSPITAL

WKH represents the coming together of several aspects of the study, and this coming together happens at different levels. With regard to the *aims of this study*, a unique integration is pursued between psychiatric patients' experiences, the concept of the therapeutic relationship, and the training of psychiatric registrars in psychotherapy. From one perspective it can be said that I am in a unique position to conduct this particular integrative study because of my appointment at WKH (specifically in the Team for Mood and Anxiety Disorders where psychotherapy forms a large part of the patients' treatment), my background and experience in psychodynamic psychotherapy, and my academic departmental responsibility to train psychiatric registrars in psychotherapy.

But I also became aware of the pitfalls of insider research during this study. While my different roles in the hospital are a positive for this study, they are also a potential source of conflict. These roles are that of:

- A consultant psychiatrist, jointly appointed by the University of Pretoria, responsible for the training of registrars.
- A consultant psychiatrist, jointly appointed by the Department of Health, responsible for patient care.
- A researcher, who has an ethical obligation towards the participants of this study and their proper care. This includes the proper reporting of the findings of this study.

## 1.7 ANTICIPATED CONTRIBUTIONS

### 1.7.1 Theoretical contributions

My aim is to develop a model and theory of therapeutic relationships in a psychiatric hospital, and to understand how this is enveloped in and influenced by other factors operating in a psychiatric hospital. A model and theory of therapeutic relationships in a psychiatric hospital can be used to come up with suggestions about the training of our registrars.

A theoretical contribution will be a better understanding of the development of therapeutic relationships in a psychiatric hospital, with whom they develop and why. The situation in our hospital can also be compared to what is known elsewhere in the world and how our unique situation in South Africa influences the therapeutic relationship and as a result the care of psychiatric patients in a typical South African psychiatric hospital.

Another contribution would be to become aware of possible shortcomings in the training of the registrars of the Department of Psychiatry, University of Pretoria, and, if found, to come up with suggestions how these can be addressed. In addition, attending to other factors operating in a psychiatric hospital can also identify problems other staff members encounter, and to think about possible avenues to address these.

### **1.7.2 Methodological contributions**

Most research in psychiatry is of a quantitative nature; therefore, a qualitative study on experiences of hospitalised patients will be of value.

### **1.7.3 Practical contributions**

It is important to understand what is valuable and beneficial to patients and how they interact with the service offered, especially in an academic setup like WKH. If we know more about the world of the psychiatric patient, this can lead to a better understanding of the patient, which in turn can help to improve treatment.

Batho Pele, a Sesotho word meaning “people first”, is an initiative that was launched by the government in 1997 to improve service delivery. It consists of eight principles to be followed in the service to people; these are: consultation, service standards, redress, access, courtesy, information, transparency and value for money. My project links up with the Batho Pele Principles of improving service delivery, especially with the principle of consultation, which means to “interact with, listen to and learn from the people you serve”,

and the setting of service standards (Education and Training Unit for Democracy and Development; Batho Pele 2013). This project is an attempt to help identify and address unmet needs of patients, or to help correct mistakes made in the process of treating patients.

Lastly, registrars will deliver a better service if we improve their training.

## 1.8 EXISTING KNOWLEDGE

In the last couple of years the importance of the therapeutic relationship, as well as patient satisfaction, have gained prominence since both might influence the outcome of treatment (Krupnick et al. 1996; Mintz and Flynn 2012; Falkenström, Ganström and Holmqvist 2013). Del Canale et al. (2012) showed in their research that patients of physicians who scored high on empathy had a significantly lower rate of acute metabolic complications than patients of physicians who scored moderate or low on empathy. Priebe and Gruyters (1995) found in a study of 34 patients suffering from schizophrenia that patients who were dissatisfied with their treatment had significantly longer duration of subsequent hospitalisations. Yet research in biological and pharmacological approaches still receives far more funding than psychosocial approaches (Soldani et al. 2005; Ghaemi 2006).

Most studies of patient satisfaction are of a quantitative nature. There is a lack of qualitative studies about what is happening on psychiatric wards (Thomas, Shattell and Martin 2002; Johansson and Eklund 2003). Although the paper by Thomas et al. in which they state that “(n)ot since Goffman’s *Asylums* (1961) has there been an in-depth examination of the phenomenal world of the hospitalised psychiatric patient” (p. 99) was written in 2002, not much has changed since then.

For the research proposal, our librarian and I did a limited literature review. After the data collection phase of this project we did an extensive literature search. Key words used were:

- Psychiatric hospitals, long-term care, inpatients, needs assessment, patient experiences and satisfaction, social support, experiences, meaningful experiences, quality of life.

- Training, medical education, internship or residency, residency in psychiatry, physician-patient relationship, psychotherapy, staff development.
- Patient-centred care.
- Therapeutic relationships.
- Containment, contain.
- Professional-family relations, inter-professional relations, professional competence, communication, communication barriers.
- Systems theory.

## 1.9 THESIS STRUCTURE

The thesis consists of four sections.

Section 1, 'The study and its methodology', I divided into two chapters.

In Chapter 1, I started with giving a short overview of the background to the study and of the registrar training. I then stated the purpose of the research, followed by the problem statement, research question, aim and objectives. I ended with describing my personal interest in this study, the anticipated contributions and gave a short overview of existing knowledge.

In Chapter 2, I describe the research approach and philosophy. I attend to the place of literature and theory in qualitative research, research ethics and my research design and methodology. I also discuss the problems of trustworthiness and quality control in qualitative studies.

In Section 2, I discuss the findings, which I have divided into five chapters (Chapters 3 to 7).

In Chapter 3, I give an introduction to WKH and the admission process, as well as a profile of the 15 patients who participated in the study. To make sense of the data, I developed several models to represent the information gathered and I explain these models and the process of developing them.

Chapter 4 is about the hospitalisation process and initial experiences of patients in the hospital. I also explore the experiences of patients in the open and closed wards. The chapter ends with examples of the unfortunate violations of the rights of patients.

Chapters 5 and 6 are about primary and secondary factors that play a role in holding and containment.<sup>2</sup> I describe patients' experiences with the various team members, e.g. nursing staff and registrars. Religion, spirituality, culture and language, although important topics, were not a focus of this study and I give only a short introduction into these topics in Chapter 6.

Chapter 7 is about the therapeutic relationship. I discuss factors that influence this relationship and end by asking if such relationships can be developed in our challenging situation.

Section 3 is titled 'Towards a model of therapeutic relationships in a psychiatric hospital'.

Chapter 8 represents the literature review, while an interpretation of the findings and the development of a model and theory of therapeutic relationships in a psychiatric hospital are offered in Chapter 9.

Chapter 10 is an analysis of the trustworthiness of the study. I discuss concerns about both case study and insider research and explain the strategies I used to assure quality.

The final section of the thesis, Section 4, contains two chapters. A synopsis of the study, is given in Chapter 11. I also outline the key implications of the research findings, the conclusions reached and recommendations made. Chapter 12 comprises my personal reflections on the doctoral journey.

---

<sup>2</sup> I describe holding and containment, central concepts of this thesis, in Section 8.4.7.

## **2 RESEARCH APPROACH AND ITS IMPLEMENTATION**

### **2.1 INTRODUCTION**

In this chapter, I describe the research approach and methodology that I followed in this study. More particularly I outline (i) the broad qualitative approach I used; (ii) my research philosophy; where I stand with regard to ontology and epistemology; (iii) my beliefs with regard to the place of literature in qualitative research and how I relate theory and research; (iv) research ethics; (v) the particular qualitative strategy I applied; (vi) my research methodology; that is, the key decisions I took in conducting the research, and (vii) how I attempted to ensure that the study would be regarded as trustworthy.

### **2.2 QUALITATIVE RESEARCH AS RESEARCH APPROACH**

In the extensive literature research done by our librarian and myself (mentioned in Section 1.8), we did not find any first-person accounts of patients' lived experience on inpatient units done in South Africa, except the study done by Müller and Poggenpoel (1996) in which they describe 13 patients' internal world experience of interacting with psychiatric nurses.

I also did not find articles about experiences of patients with registrars in South African psychiatric hospitals. We do not know what the registrars really practice on the wards. I already mentioned that the training of registrars in psychotherapy is a big challenge. My impression, formed after having worked in psychiatry for three decades and in six psychiatric hospitals as well as attending conferences in South Africa, is that South African psychiatry gives lip service to the importance of psychotherapy, but it is not really taken seriously and seldom practiced by psychiatrists. Because of that, the therapeutic relationship suffers.

Local knowledge on patients' experiences and views, as well as therapeutic relationships in psychiatric hospitals, is limited and this makes qualitative research methods an appropriate choice. My aim with a qualitative approach was to explore and describe

patients' experiences and interactions in the hospital, as well as the diverse meanings they attach to these experiences (Schurink et al. 2006; Delport, Fouché and Schurink 2011).

But what does qualitative research entail?

Denzin and Lincoln (2005: 3) give the following generic definition of qualitative research:

Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings, and memos to the self. At this level, qualitative research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them.

In quantitative research, there is a belief that human behaviour can be explained from the outside by the means of objectivistic observation. In contrast, qualitative research assumes "that human behaviour can only be understood from an insider's point of view by gaining insight into the meaning (*verstehen*) that the participant gives to his/her life world" (Schurink 2009: 788). Qualitative researchers try to get closer to the actor's perspective through detailed interviewing and observation. They are also more likely than quantitative researchers to come up against the constraints of everyday social world (Denzin and Lincoln 2005).

Qualitative research is concerned with understanding; it is a broad umbrella term for research methodologies that describe and explain persons' experiences, behaviours, interactions and social contexts (Strauss and Corbin 1990). Qualitative approaches are especially appropriate in understanding subjective experiences of health, disease and treatment (Fossey et al. 2002).

## 2.3 MY RESEARCH PHILOSOPHY

“The first thing a researcher must outline is the paradigm that underpins the study – the researcher’s point of view, or frame of reference for looking at life, or understanding reality” (Delpont et al. 2011: 297). Paradigms are fundamental orientations, perspectives or worldviews that ultimately are neither true nor false, but only more or less useful (Delpont et al. 2011). “The net that contains the researcher’s epistemological, ontological, and methodological premises may be termed a *paradigm*, or an interpretive framework...” (Denzin and Lincoln 2005: 22). All research is interpretive, guided by the researcher’s set of beliefs and feelings about the world and how it should be understood and studied (Denzin and Lincoln 2005).

The first question when designing a qualitative study is how social reality should be looked at (Fouché and Schurink 2011). It is the belief about ontology or the nature of reality (Creswell 2013). Three major ontological frameworks are objectivism or positivism; interpretivism; and constructivism or postmodernism (Delpont et al. 2011; Fouché and Schurink 2011). Objectivism posits that there is an external reality that can be studied objectively; the life world of subjects can be discovered in an objective manner. Interpretivism focuses on meaningful social action; meaning is created and reality should be interpreted through the meaning that research participants give to their world and how they interact with each other (Van Wynsberghe and Khan 2007; Fouché and Schurink 2011). According to constructivism or postmodernism there is no real world out there, only a narrative truth; reality is a personal construct (Fouché and Schurink 2011).

Interpretivism is a philosophical theory of meaning and understanding and has its roots in the 19<sup>th</sup> century. Understanding was considered to be a process of psychological reconstruction (Nieuwenhuis 2007a). Nieuwenhuis writes that the problem with this original conception is a belief in the possibility of achieving a single correct interpretation. A more sceptical view of interpretation on the other hand runs the risk losing itself in subjectivism and relativism. Heidegger described this dilemma as a ‘hermeneutic circle’ in which understanding and interpretation, part and whole, are related in a circular way (Nieuwenhuis 2007a).

The interpretivist perspective is based on the following (Nieuwenhuis 2007a):

- Human life can only be understood from within.
- Social life is a distinctly human product.
- The human mind is the purposive source or origin of meaning.
- Human behaviour is affected by knowledge of the social world, social theory informs our understanding of issues.
- The social world does not 'exist' independently of human knowledge.

In qualitative research the idea of multiple realities is embraced and reported on (Creswell 2013). The same experiences are viewed differently by different people. Knowledge is not conceived as a 'mirror of reality', but as a social construction in which the focus is on interpretation and the creation of meaning (Kvale 1996).

Since the aim of this study is to understand patients and the subjective meanings attached to their experiences in hospital, I aligned myself with a framework of interpretivism as described by Van Wynsberghe and Khan (2007), Fouché and Schurink (2011) and Creswell (2013). In interpretivism, individuals seek understanding of the world in which they live and work and develop subjective meanings of their varied and complex experiences. Since these meanings are often formed through interaction with others it is also called social constructivism (Creswell 2013). The different points of view of the participants are thus central to the research; from this a theory is then inductively developed.

The interpretation given by researchers to their findings is shaped by their own experiences and background, but the intent is to make sense of the meanings others have about the world (Creswell 2013). I started with the assumption that many registrars and psychiatrists have a biological and symptom-orientated approach to patients and neglect the therapeutic relationship. Furthermore, that patients often feel disconnected and have a wish for a therapeutic relationship and to be understood, and, if a therapeutic relationship does not develop with their registrar, therapeutic relationships with other team members or with fellow patients become more important. Neglect of the therapeutic alliance will have a negative influence on treatment outcome.

The framework, or ontology, leads to the question of epistemology. Epistemology asks the questions: How is reality known? What counts as knowledge? How is knowledge claims justified? (Creswell 2103). It asks the question about the relationship between the inquirer and the known (Denzin and Lincoln 2005). Subjective evidence is assembled based on individual interviews; knowledge is known through the individual experiences of people. In qualitative studies researchers therefore try to get as close as possible to the participant studied, to become an ‘insider’ (Creswell 2013). This closeness is, for example, manifested through time spent in the field and the impact of the research on participant and researcher. In reporting, the researcher will also rely on quotes as evidence from the participants (Creswell 2013).

## **2.4 THE PLACE OF LITERATURE IN QUALITATIVE RESEARCH AND THE RELATION BETWEEN THEORY AND RESEARCH**

It was and still is not uncommon for qualitative researchers to state that there is no need to start with a review of the existing literature. The idea was to explore new, undiscovered areas and not to be influenced by existing theory, which could restrict and hinder the research process (Delpont et al. 2011). This has changed and there is an increasing agreement that theory has a place in qualitative research, yet currently there is no consensus as to the best use of it (Delpont et al. 2011).

The questions about the place of theory and the place of a literature review are related, but the difference between theory and literature review should be kept in mind. Theory provides an explanation for phenomena and it helps direct our inquiry. “Relevant and appropriate theories thus form the theoretical framework of an empirical study, and the literature review should be organised around the theories” (Delpont et al. 2011: 302). A literature review, according to Mouton (2001), is a review of existing scholarship. “You want to learn from other scholars: how they have theorised and conceptualised on issues, what they have found empirically, what instrumentation they have used and to what effect” (Mouton 2001: 87).

Mouton (2001: 87) lists the following reasons why a literature review is important:

- To ensure that one does not merely duplicate a previous study.

- To discover what the most recent and authoritative theorising about the subject is.
- To find out what the most widely accepted empirical findings in the field of the study are.
- To identify the available instrumentation that has proven validity and reliability.
- To ascertain what the most widely accepted definitions of key concepts in the field are.

Wolcott (2002) is of opinion that readers want to immediately engage with the problem the researcher is addressing, not a review of how learned he or she has become. The literature review should, according to him, be held back; it does not need to slot into chapter two as it is usually done. I aligned myself with Mouton (2001) and Wolcott (2002) and initially did a limited literature review; I thus followed a deductive approach to come up with a research proposal. Then I turned from the literature to the patients for the data gathering. After I collected my data I did an extensive literature review that forms Chapter 8 of my thesis.

About the link to theory, Wolcott (2002: 97) writes the following:

If you have the choice – that is, if you are not directed otherwise – consider integrating theory, or introducing your concerns about theory, into your account at the place where such concerns actually entered your thinking, rather than feel obligated to slip theory in at the beginning as though it prompted or guided your research all along.

Theory and literature review are, however, also used differently within the different research designs available in qualitative research. In a grounded theory study one collects and analyses data before using any theory. The researcher cannot provide a theoretical framework as the intention of grounded theory is to generate theory (Delpont et al. 2011). In a case study design the use of literature and theory is often very varied. It might be completely absent, with the focus on the description of the case, or theory could be used to guide the study in an explanatory way (Delpont et al. 2011).

Research leads to the development of models and of theory. A model is a partial representation of a given phenomenon; it is a simplification that draws attention to specific themes. This drawing of the attention to something specific is a guiding function of a

model, a heuristic function, and the model is therefore used to suggest new areas of research. A model has thus a heuristic function and a theory an explanatory function. The relationship between a theory and the phenomenon that it explains is much more specific than the relationship between a model and the phenomenon to which the model relates (De Vos and Strydom 2011).

Theory in the social sciences comes in three levels: grand theory, theory of the middle range and low-level theories built to explain a given set of data. According to Creswell (2013) the objective in grounded theory is to generate a substantive theory, which is a low-level theory that is applicable to the immediate situation.

Grounded theory, developed by Glaser and Strauss (1967), is a general methodology for developing theory that is grounded in data which is systematically gathered and analysed (Bowen 2008). It is based on two concepts: constant comparison and theoretical sampling. “Theoretical sampling means seeking pertinent data to develop an emerging theory. The main purpose of theoretical sampling is to elaborate and refine the categories constituting a theory” (Fouché and Schurink 2011: 319). Constant comparison refers to an iterative process of comparing fragments of data and categories constantly and repetitively with one another during the stages of data analysis. New data gathered is constantly compared to previous data in order to generate theory. The aim is to look for similarities and differences in the data. In this way underlying uniformities are identified and a coded category or concept is produced.

Theoretical saturation, a defining characteristic of grounded theory, relies on the process of constant comparison (Bowen 2008). “Data analysis involves systematic coding procedures... Previously coded text is checked to see whether newly created codes are relevant for developing and refining theoretical categories or central concepts” (Bowen 2008: 139).

Categories are clustered together to form themes and by proposing plausible relationships between themes a theory is formed (Fouché and Schurink 2011). In a grounded theory study, the researcher generates an abstract, analytical schema of a phenomenon. A theory is developed to explain actions and interactions, or a social process (Frost et al. 2010; Creswell 2013). Theoretical saturation is reached when no new categories emerge (Fouché and Schurink 2011; Creswell 2013).

## 2.5 THE PROCESS OF CODING AND DIFFERENT WAYS OF DATA ANALYSIS IN THE DEVELOPMENT OF THEORY

The coding of data is central in grounded theory in order to progress from data to theory. Researchers do not start with a theory and then prove it, they begin rather with a specific study, and what is relevant to this study is allowed to gradually emerge. (Psychoanalytic psychotherapy is similar to this process.) Data collection, analysis and theory stand in a reciprocal relationship with one another. To analyse the data, open, axial and selective coding is used (Fouché and Schurink 2011).

In formal analysis, data is coded to help with category formation. Coding reduces the data into themes (Creswell 2013). The basic analytic procedure followed in the coding process comprises of the following (Schurink, Fouché and De Vos 2011; Creswell 2013):

The labelling of phenomena or conceptualising of data, leading to grouping of concepts and the discovering of tentative categories.

Categories are developed in terms of their properties (characteristics or attributes) and dimensions (their location on a continuum). This involves coding of which grounded theory utilises three methods:

- **Open coding.** By segmenting information, categories of information about the phenomenon being studied are formed. Open coding serves to reduce the mass of data into manageable groupings (Bowen 2008). Phenomena are named and categorised and by constant comparison, categories are integrated and refined. “By engaging in line-by-line coding, the researcher makes a close study of the data and lays the foundation for synthesizing it” (Charmaz 2005: 517). Using constant comparison the researcher looks for data that represent the category until the new information obtained does not provide further insight into the category. In this process, the data is reduced to a small set of themes or categories (Creswell 2013).
- **Axial coding.** Following open coding, the data is assembled in new ways. It is about interconnecting the categories. “In grounded theory we link subcategories to a category in a set of relationships denoting causal conditions, phenomena, context, intervening conditions, action/interaction strategies and consequences” (Schurink et

al. 2011: 413). Data is linked in a more complex and abstract way. There is a move from a descriptive to an interpretive and explanatory mode (Bowen 2008).

- **Selective coding.** This is “the process of selecting the core category, systematically relating it to other categories, validating those relationships and filling in categories that need further refinement and development. During the coding process, the researcher constantly moves between these three methods” (Schurink et al. 2011: 413). Axial codes can be connected and consolidated, and selective codes analysed to identify themes that cut across data; these can be further distilled to create core categories of emerging themes (Bowen 2008). The categories have to be integrated to build a theory, which can assume several forms, such as a visual picture or a series of propositions. A story line is written that connects the categories. It is important to note that codes are *applied* to the data, but *themes* emerge from the data (Bowen 2008).

The result of this process of data collection and analysis is a theory. According to grounded theory, codes and the final theory should only emerge from the data, not the extant theory (Xu and Storr 2012). A theory is an explanation of something or an understanding flowing from the data and developed by the researcher (Creswell 2013).

Qualitative data analysis, writes Nieuwenhuis (2007c), is best achieved through a process of inductive analysis of data

where the main purpose is to allow research findings to emerge from the frequent, dominant or significant themes inherent in raw data, without the restraints imposed by a more structured theoretical orientation. Using a more deductive approach where the categories of information required from the data are formulated in advance ...may often obscure or render key themes invisible. (Nieuwenhuis 2007c: 99)

Deductive reasoning moves from the general to the specific; from a pattern that might be theoretically expected to observations that put this to test. Inductive reasoning begins with an observation and then moves towards a theoretical construct (Delpont and De Vos

2011). According to Kelle (1995) it is a misunderstanding that researchers, following grounded theory, should use an inductivist strategy, understood as the need for an *empty head* devoid of any theoretical constructs that could blur the unprejudiced observations of the research. Following on from this, the question for Richardson and Kramer (2006) is how existing theoretical ideas can be used in grounded theory to contribute to a meaningful story of the phenomena under study. In their opinion, abductive inferences, using explicit theoretical insights, can contribute to creative thinking.

Shank (1998) states that for centuries empirical reasoning in the western world was ruled by deduction, which limited the growth of scientific inquiry. The later development of inductive reasoning launched a scientific revolution, in spite of inductive methods having crucial drawbacks, e.g. it leads to probable instead of certain conclusions (Shank 1998).

The concept of abduction was introduced by the philosopher C.S. Peirce in 1955 (Shank 1998; Richardson and Kramer 2006). Abduction, a type of inference distinguished from both induction and deduction, focuses on finding explanations for observed facts, it is a method for making sense of new (or unknown) situations (Cunningham 1998). It is a process by which useful explanations are developed; this process is essentially '*an inference*' from observed facts (Richardson and Kramer 2006). Peirce illustrated what is meant by abduction by comparing it with deduction and induction; Shank (1998: 847) expands on these examples of Peirce in the following way:

#### **Deduction:**

Rule: (It is true that) all the beans from this bag are white.

Case: (We know that) these beans are from this bag.

Result: (Certainly, it is true that) these beans are white.

#### **Induction:**

Case: (We know that) these beans are from this bag.

Result: (We have observed that) these beans are white.

Rule: (Probably, then) all the beans from this bag are white.

## Abduction:

- Result: (We have the experience that) the beans are white (but this experience lacks any real meaning for us.)
- Rule: (The claim that) all beans from this bag are white (is meaningful in this setting.)
- Case: (Therefore, it is plausible and meaningful to hypothesize that) these beans are from this bag.

Abduction is thus the reasoning from the experience to the case; “it is the act of using some sort of hypothetical rule or claim in order to render what might be a unique experience into a commonplace example of some more general phenomenon” (Shank 1998: 847). “(A) new idea or a hypothesis (these beans are from this bag) is added to two ‘givens’ (the rule and the result)” (Richardson and Kramer 2006: 500).

In abductive inference the perspective and experience of the researcher, the existing knowledge and theory and the findings of the present study are used to create new insight and knowledge. Individual facts are collected and connected together and connected to ideas in order to develop hypotheses; “the process of associating data with ideas *is* abduction” (Richardson and Kramer 2006: 500). Atkinson and Delamont (2005) describe abductive logic as exploring the social or natural world through practical engagement with it, deriving working models and provisional understandings and use such emergent ideas to guide further empirical explorations. “It represents a compromise between the arid philosophy of purely deductive logic ... and purely inductive logic” (Atkinson and Delamont 2005: 833). In deductive logic, according to Atkinson and Delamont (2005), there is no place for experience in the process of discovery, and purely inductive logic “never transcends the collection and aggregation of observations in generating generalizations” (p. 833).

As described by Atkinson and Delamont (2005), Richardson and Kramer (2006) and Nieuwenhuis (2007c), I made use of inductive and abductive logic to generate a substantive theory.

## 2.6 RESEARCH ETHICS

Scientific research has to conform to generally accepted norms and values. Codes and ethics have been developed in the various disciplines, for example in the field of medicine and psychology to protect vulnerable groups such as patients. Mouton (2001: 238 – 248) discusses research ethics under the following four categories of obligations or responsibilities of the researcher:

### **i. Relationship to the practice of science (professional ethics)**

This refers to the moral commitment that scientists are required to make to the search for truth and knowledge. It includes objectivity and integrity in research, no fabrication or falsification of data, the recording of own data and ethical publishing practices.

### **ii. Relationship to society**

The most important principle is accountability to society, which manifests itself in the following ways: no secret or clandestine research, free and open dissemination of research results and responsibility to funders.

### **iii. Relationship to the subjects of science**

The rights, sensitivities and interests of the participants must be protected. This includes the right to privacy, to anonymity and confidentiality, to informed consent and not to be harmed in any manner.

### **iv. Relationship to the environment**

Research should not damage or harm the environment in any way.

## **Ethical and legal considerations in my study**

I requested approval by the management of WKH and the Research Ethics Committee of the Faculty of Health Sciences of the University of Pretoria, as laid down in the Helsinki Declaration (last update: October 2008). Participation was voluntary and written informed consent was obtained from all participants. Anonymity or confidentiality and privacy of

information were adhered to. Qualitative researchers are privileged guests in the private space of participants; great caution should be exercised to minimise risks to participants (Stake 2005).

Individual patients' capacity to consent to participation in this study was assessed clinically by evaluating if the patient understands what the study is about and whether the patient thus understands what he or she consents to. Each patient was also assessed if he or she is able to choose decisively for or against participation; whether he or she can communicate his or her consent and if his or her mental disorder prevents him or her understanding, choosing and communicating the above (Van Staden and Krüger 2003). (This is also discussed in Section 2.7.2: 'Study population and sampling'). A participant was free to withdraw at any time if troubled by any aspect of the research.

There is and was no substantial risk for patients having participated in this study. It can however benefit services to patients as well as training of registrars. To be part of research focussed on improving service delivery could also be a positive experience for patients.

## 2.7 QUALITATIVE RESEARCH DESIGN

What is called research *approach* by Creswell (2013), is called research *design* or *strategy* by Fouché and Schurink (2011) and research *strategies* by Denzin and Lincoln (2005). For Creswell *research design* refers to the entire process of research, adding to confusion around the definitions of certain concepts. I shall keep to the terminology used by Fouché and Schurink (2011).

I discussed the research design with Professor Schurink and Professor Krüger and we decided to choose a case study. The focus of the study is to examine and describe a specific, bounded system in depth. The 'case' or 'bounded system' in my study refers to the in-depth study of 15 adult inpatients of WKH over a period of six months from October 2013 to March 2014. Forensic patients were excluded from this study. An in-depth case study was required to reveal the complexities of the system and to reach a detailed understanding from which generalisations could be made from what was learned (Creswell 2013). We decided, however, to use the methods developed in grounded theory for the

analysis and synthesis of the data. This decision was based on my idea to not only describe the situation in depth, but to also develop a theory or explanation of what was happening in the hospital, how this affected therapeutic relationships, and what aspects needed to be kept in mind to allow the possibility of therapeutic relationships to evolve. This theory would be developed from the data gathered, thus 'grounded' in the data.

But what is a case study? Case study research is defined by interest in an individual case, not by the methods of inquiry used. The epistemological question is: What can be learned about this case? (Stake 2005). According to Van Wynsberghe and Khan (2007) a case study can be congruent with an interpretivist paradigm. A case study involves an exploration of a 'bounded system' over a period of time through detailed, in depth collection of data using multiple sources of information such as interviews, documents and observations (Fouché and Schurink 2011). The case or bounded system being studied might be a process, activity, event, programme, individual or a small number of people (Mouton 2001; Fouché and Schurink 2011). 'Bounded' refers to time, context or place. Creswell (2013) writes that a bounded system is often bounded by place and time, but also has interrelated parts that form a whole. The proper case to be studied is thus both 'bounded' and a 'system'. Studying the situation in WKH fulfils these criteria.

The product of this approach is an in-depth detailed description of a case or cases to develop a rich, comprehensive and in-depth understanding. Focussed on a small number of people it would be an attempt to reach a comprehensive and holistic understanding of how participants relate and interact with each other in a specific situation (Nieuwenhuis 2007b; Fouché and Schurink 2011). A case study allows for research in complex, naturalistic settings, because it advances the concept that complex settings cannot be reduced to single cause and effect relationships (Van Wynsberghe and Khan 2007).

Different types of case study are (Fouché and Schurink 2011):

- A descriptive or intrinsic case study: a description, analysis or interpretation of a particular phenomenon; an intensive study might involve only a small number of cases.
- The explanatory or instrumental case study: the purpose is theory building and testing, new knowledge generated might inform policy development.

- The collective case study, in which an instrumental case study is extended to a number of cases. Cases are chosen to enable comparisons between cases and concepts and to extend or validate theories.

However, the designs of different types of case study often overlap (Fouché and Schurink 2011). My research fits in with the description of a collective instrumental case study, a case that is examined to provide insight into an issue and to redraw a generalisation (Stake 2005; Creswell 2013) and will follow an explorative-descriptive approach. Stake (2005) says the brainwork of a case study is ostensibly observational, but more critically, it is reflective.

## 2.8 RESEARCH METHODOLOGY

Henning, Van Rensburg and Smit (2004) differentiates between ‘methods’ – a way of doing something – and ‘methodology’, which refers to a coherent group of methods that complement each other and have a ‘goodness of fit’, to thus deliver data and findings congruent with the research process and the research purpose. Mouton (2001) states that research methodology indicates *how* one intends conducting the fieldwork, it refers to the research process which according to him includes the literature study, sampling, measurement, data collection, data analysis and interpretation.

In qualitative research, methodology is not a linear but rather a circular process: literature review, research design, data collection, analysis and interpretation are repeatedly revisited leading to a deepening of the research (Eriksson and Kovalainen 2008). An important part of this circularity is the process of reflexivity, which refers to a constant reflection and critical inspection of the whole process. The researcher is the primary instrument and integral part of the research process and the quality of the data obtained is contingent on the expertise of the researcher, one example being his interviewing skills (Eriksson and Kovalainen 2008; Xu and Storr 2012).

The key decisions and steps I took in executing the study follows. These decisions and steps are (i) the study setting; (ii) study population and sampling; (iii) sample size and data

saturation; (iv) collection and recording of data; (v) data management; (vi) data analysis and synthesis, and (vii) writing up.

### **2.8.1 Study setting**

As already described in Chapter 1, the study was done in WKH, Pretoria. Since I am a joint appointee at WKH and the University of Pretoria, this study can be described as insider-research, which is usually defined as studying a group to which the researcher belongs (Breen 2007). Three key advantages of being an insider-researcher are according to Bonner and Tolhurst (2002): (a) having a greater understanding of the culture being studied; (b) not altering the flow of social interaction unnaturally; and (c) having an established intimacy which promotes both the telling and the judging of truth. Unluer (2012) notes that in her case study research being an insider had several advantages, for example in determining the case, defining the researcher's role to participants and access to the research site and data. She also describes problematic situations that may arise and need to be considered in insider-research, such as ethical issues, bias, role duality and obtaining sensitive information about the personnel or colleagues and not reporting this information in the final report.

There were several advantages to doing this specific study in WKH:

- Patients with the necessary experience to answer the research question and from all the different diagnostic groups are admitted to this hospital.
- It is an academic hospital and as such is concerned with training of registrars.
- As part of the academic setup multi-disciplinary teams treat all patients and part of this research is about therapeutic relationships with all of these team members.
- Logistical reasons: being able to revisit patients if necessary.
- My familiarity with the situation and the patients. Having worked in WKH and having thought about the situation for a couple of years made it easier to establish connections with the patients and to reach an understanding of the patients and the situation.

## **2.8.2 Study population and sampling**

The study population were patients admitted to the different teams as adult patients in WKH. This boundedness is consistent with an instrumental case study design (Creswell 2013).

In designing a study, nothing is more important than making a representative selection of cases; for this, formal sampling is needed (Stake 2005). The sampling of patients was guided by the following:

- I informed the consultant psychiatrists of the different teams about the study and requested them to provide names of possible participants.
- The different consultants all have weekly team meetings during which all the patients of the respective teams are discussed. Following on these meetings I was given names of patients they thought met the inclusion criteria.
- I then interviewed possible participants for voluntary participation in the study.
- I looked for participants with specific experiences of psychiatric treatment, for example, a longer period of treatment, specific problems with their treatment, or complaints about treatment, positive experiences with regard to their treatment, or participants with whom team members identified specific problems.
- The selection was targeted to include male and female patients of different race, backgrounds and diagnostic groups and from the different teams in the hospital.
- Participants should be able to express themselves well in English or Afrikaans. I am of opinion that it would have created problems if I had used an interpreter. Such a step could have led to the loss of a more intimate, secure space and to patients finding it more difficult to open up. It would also have raised the issue of confidentiality.

One aspect I kept in mind was how patients with different diagnoses would respond, for example patients with a psychotic disorder. Patients were only included if their consultant psychiatrist was of the opinion that the patient was stable enough to participate and able to express themselves coherently in an interview.

I found that two patients interviewed were psychotic. I discussed this with my supervisor and we decided to include them in the study, because of several reasons: the referring registrars and consultant psychiatrists were of the opinion that they would be able to understand the study and give informed consent and would be able to express themselves in a coherent way. During my initial contact with these two patients, I also had the impression that they could understand what the study was about and could express their experiences in a cogent way. A psychosis is not always a condition in which there cannot be parts of the personality that are still in contact with reality, as illustrated by this quote from Saks (2007: 216): "... we both started laughing, him with relief, me still delusional but cogent enough to be embarrassed at the scene I'd caused." Furthermore, I took note of what Van Staden and Krüger (2003) have written on this. According to them, to claim that someone who is psychotic cannot give informed consent is over-inclusive, since such a claim is based on a diagnosis and not on "the assessment of a particular patient's capacity to give consent, neither specifically for each intervention nor at the time when the consent has to be given" (Van Staden and Krüger 2003: 41). Ethical aspects linked to the problem of consent are also discussed in Section 2.6: 'Research ethics'.

An effort was made to include patients from different teams and under treatment with different registrars. The 15 patients interviewed had been in the care of 12 of the present 18 registrars; some had seen other registrars during previous admissions.

Purposive sampling, an accepted procedure in qualitative research, means that the selected participants were those who were thought to be the richest source of information for the specific research question (Nieuwenhuis 2007b). According to Bowen (2008), qualitative research typically uses purposive sampling; the emphasis is on quality rather than quantity. Stake (2005) writes, that in sampling, balance and variety are important but opportunity to learn is often more important, and to therefore select a case from which we feel we can learn the most. Training, experience and intuition can help us to make a good selection (Stake 2005). Maximum variation sampling helped to ensure that the views of previously disadvantaged or disempowered patients were represented (Fossey et al. 2002).

Sampling and interviewing was done from October 2013 until March 2014 and the number of patients interviewed was determined by data saturation (Fossey et al. 2002). No patient

had refused to participate and my impression was that 13 of the 15 patients were eager to very eager to participate. Only two initially made a guarded impression.

### **2.8.3 Sample size and data saturation**

Samples for qualitative studies are generally much smaller than those used in quantitative studies. There are several reasons for this, e.g. in a qualitative sample there is a point of diminishing return and more data does not necessarily lead to more information. Frequencies are rarely important; one occurrence of a piece of data is all that is necessary to ensure that it becomes part of the study, since qualitative research is concerned with meaning and one piece of information is potentially as useful as many in the process of understanding (Mason 2010).

Sample size should, according to Fossey et al. (2002), generally follow the concept of saturation. *Data saturation* means that new participants add nothing new to the study. *Theoretical saturation* is reached when no new insights are obtained and no new themes or issues are identified. Theoretical saturation is a consequence of theoretical sampling, where the focus is less on sample size and more on sampling adequacy (Bowen 2008). According to Bowen (2008), data saturation *or* theoretical saturation is essential to naturalistic enquiry, the purpose of which is to describe and interpret some human phenomenon.

Bowen (2008) states that explicit guidelines for determining saturation are almost non-existent. There are several factors that can influence saturation. Charmaz (2006) suggests that the aims of the study will determine the sample size; a small study might achieve saturation quicker. The expertise of the researcher in the chosen topic can also reduce the number of participants needed (Jette, Grover and Keck 2003). The skill of the interviewer and thus the quality of interaction between researcher and participant is another factor of importance, since this will have an effect on the quality of the study and data saturation (Morse 2008; Mason 2010).

Guest, Bunce and Johnson (2006) write that many journals in the health sciences require that theoretical saturation should be a criterion by which to justify adequate sample size in qualitative research, yet no description of how to determine saturation, or guidelines for estimating sample sizes to reach saturation, are provided. They prefer to keep to the term 'data saturation', since the term 'theoretical saturation' refers specifically to the development of theory in a grounded theory approach. "Theoretical saturation occurs when all of the main variations of the phenomenon have been identified and incorporated into emerging theory" (Guest et al. 2006: 65).

Using data from a study they did involving 60 in-depth interviews Guest et al. (2006) systematically documented the degree of data saturation over the course of thematic analysis. Based on this they posit that saturation had for the most part occurred by the time they had analysed 12 interviews. After 12 interviews, they had created 88 per cent of the total number of codes developed for all 60 interviews and 92 per cent for one part of the study. The assumption here is that there will be a certain degree of structure within interviews; in other words, a similar set of questions will be asked. Guest et al. (2006) emphasise that it also depends on how you want to use the data and what you want to achieve. If the goal is to describe a shared perception, belief, or behaviour among a relatively homogenous group, then a sample of 12 will likely be sufficient according to them.

My research involved 15 participants with whom 30 interviews were held. They formed a relatively homogenous group, sharing the following characteristics:

- All were psychiatric patients admitted to Weskoppies Psychiatric Hospital.
- Their admission period was on average 12 weeks, thus a fairly long time.
- Most of them had spent two to 16 weeks in a closed ward.
- Most had a history of long-standing, severe mental illness.

In my study, I generated 338 codes in open coding of the data. Of these, only six codes came from the interview with the 14<sup>th</sup> participant. With the 15<sup>th</sup> participant, an intelligent woman and the only participant who had made notes of her experiences before the first interview, only four new codes were added, of which two were about the admission process and a general appreciation of the Substance Rehabilitation Unit, one was about

the benefit of exercise, and only one about the patient's interaction with her treating registrar. My supervisor and I concluded that I had reached saturation after 15 patients. In deciding this we took the following into consideration:

- Saturation and the number of participants needed as described by Guest et al. (2006).
- My familiarity with the setting and closeness to the participants (Creswell 2013).
- My experience in interacting with patients and building rapport.
- Only four new codes emerged from the two interviews with the 15<sup>th</sup> participant, of which only one code was about the therapeutic interaction.

#### **2.8.4 Collection and recording of data**

Multiple sources and techniques are used in a case study for data collection (Nieuwenhuis 2007b). In this study I generated data by the following multiple methods:

- In-depth face-to-face interviewing of participants.
- Observations made of participants.
- Studying of hospital files kept of participants (unsolicited documents).
- Field notes (written accounts made by me about my observations and experiences during the process of research) as well as a reflective diary (ideas, thoughts and reflections about the process) kept by me (Schurink et al. 2011).

Rapley (2001) states that in the analysis of interview data, it is important to keep in mind that talking has a social function and that participants can be concerned to present themselves in a positive way, a process he refers to as 'accounting work'. Accounting work is central to interview-talk, and we should be observant of *how* this accounting work is accomplished. An analysis of interview data should thus be sensitive to *how* the talk is produced and in which context. An interview is reliant on the skills of the interviewer and the methods used, but is produced by both speakers; it is a coordinated interactional work (Rapley 2001).

Data gathered from an interview should never be seen as merely a reflection of life outside the interview, it is rather a product of a specific interaction; data gained in an interview is

merely one possible version. According to Rapley (2001: 309) “little analytic attention has been given to the detailed ways that interview-talk is locally and collaboratively produced”.

Rapley (2001) shows how interviewing is an art and that many components contribute to it, such as the interviewer being facilitative and neutral, the phrasing of questions, and the use of silence. In conducting open-ended interviews, he writes, topic initiating questions should be followed-up by responding to the interviewee’s answer with follow-up questions to gain a more detailed and comprehensive understanding of specific topics. In representing the interview, “extracts from interviews should always be presented in the context in which they occurred, with the question that prompted the talk as well as the talk that follows being offered” (Rapley 2001: 319).

I first saw selected patients to introduce myself to them and to provide information about the study. During this short interview the Participant Information Leaflet and Informed Consent Form, which summarised the study approach and goals, was discussed and consent was obtained.

This was followed up in the next couple of days with an in-depth face-to-face interview lasting up to 70 minutes, but usually not longer than 50 minutes. The interviews were held in the ward where the patients were admitted to, usually in the office used by doctors, or otherwise in the room for visitors, but always in private. Twice, because of too much noise, we moved to another room. Once I held an interview outside in the garden, because of too much noise in the ward.

I used the research questionnaire as a guide for the interviews. The initial interview guide consisted of 22 questions. During the first interviews I extended the guide and, after having seen the third patient, the interview guide had grown to 35 questions divided into eight sections (see appendix). Initial questions of the interview were open-ended, followed by more focussed questioning. I planned to interview each patient at least twice. A patient was seen for a third time if reflection and data analysis indicated a need for a more focussed approach.

Immediately after each interview I made field notes, as recommended by Schurink et al. (2011) on each of the following points:

- Observations made during the interview

- Methodological notes
- Theoretical notes
- Personal notes

The recordings of all the first interviews were then sent by a secure electronic link to a professional company specialising in recording, typing and transcription of medical work. For a higher fee a turnaround time of less than 24 hours was agreed on. The verbatim transcriptions were thus received the following day and read twice during the next two or three days. During the first reading mistakes or omissions made by the typist were corrected. This involved listening to parts of the recordings over and over to grasp what the patient had said, since at times (even with a professional recording machine) words were inaudible, or not correctly understood by the typist. Such a correction of an interview took several hours. Then the interview was read again to do the first round of coding.

After the first coding was done, patients were seen for a second interview. If it became clear that the patient had nothing to add to the information obtained during the first interview, I stopped the recording of the second interview, although I still made observational notes. Of the 15 patients seen, 11 were seen for a second interview; of these, five were fully recorded and transcribed. Four of the patients were seen for a third interview and two of these were fully recorded and transcribed. The reason for the third interview was that I was of opinion that specific aspects mentioned by the patients needed more exploration. In total 15 patients were seen for 30 interviews.

The reasons for seeing four patients only once were:

- Patient number three was an anxious person and I decided, after re-reading the transcription, to not interview her again.
- Patient number nine was still psychotic; the patient became restless and slightly guarded towards the end of the interview and I, after discussing this patient with the registrar responsible for the patient, as well as with my supervisor, concluded that a second interview would not yield more information and would not be in the patient's best interests.
- Patient number ten was discharged on the day of the first interview.

- Patient number 14 was not seen for a second interview, since after discussion with my supervisor, we concluded that the point of saturation was reached.

I later, however, decided to see another patient, patient number 15, for two reasons. First, to make doubly sure about having reached saturation, and secondly, to conduct the last interview without the interview guide. I was interested to see whether such an interview would differ from the previous interviews steered by the guide. I did not note any difference, although it can be argued that by now I had internalised the guide and it was therefore no longer necessary.

I kept written notes (field notes) about the interviews, as well as a reflective diary about the whole research process.

After the interviews were done, transcribed and coded, I went back to study the hospital files of the patients for a second time.

### **2.8.5 Data management**

A large amount of data was generated through recording of interviews, observations, field notes and a reflective diary. All recordings were transcribed and the data properly labelled and organised into computer files. There are several computer software programs available to help organise data, such as ATLAS.ti and NVivo (Pope, Ziebland and Mays 2000; Kikooma 2010). I made use of the software program ATLAS.ti, which is available through the University of Pretoria. Before starting, I had attended a two-day workshop on the use of ATLAS.ti, organised by the University of Pretoria, and held by Doctor E. Archer from the University of South Africa.

All data is stored securely according to the Policy for the Preservation and Retention of Research Data (Rt 306/07) of the University of Pretoria.

### **2.8.6 Data analysis and synthesis as a cyclical process**

Sampling, data collection, data analysis and interpretation are interwoven in qualitative research (Fossey et al. 2002). Data analysis does not proceed in a linear fashion; it is rather 'a data analysis spiral' that already starts with the recording of field notes (Schurink et al. 2011). Observing, describing and interpreting activities constitutes a large part of many case studies, but there are often no clear stages: issue development can continue to the end of the study and write-up can begin with preliminary observations (Stake 2005).

My research project is an illustration of the cyclical process in a qualitative study. After a preliminary literature review, I started with the interviews and then read the transcriptions several times. Mulling over the data triggered more and more thoughts about what was happening in the hospital and I started with writing these down. Then I went back to expand my initial literature review and made a thorough review of important aspects of relationships. When I began to write Chapter 9 - connecting my findings with the literature review and the development of a model and theory of relationships in a hospital - I had a desire to have the patients more in mind, so I re-read all the interviews and made a summary of the most salient features that had emerged in the interviews. This happened about one year after the first readings of the transcriptions of the interviews. (I start Chapter 9 with this summary.) During this whole research process I maintained a stance of reflexivity, of thinking about the data gathered and how the data linked to my experiences in this field and the insights learned through the literature review. In this study I read all interviews five times; initially to correct any mistakes, and then another three times to identify salient themes, recurring ideas and patterns of belief. I re-read the interviews for a fifth time one year later. This re-reading was both part of an informal analysis, an immersion in the data, but also of an analysis using more formal methods of qualitative research, including methods developed in grounded theory (Schurink et al. 2011).

In the initial readings I named phenomena (open coding). Using the constant comparative method, I read and reviewed each transcription of the interviews line by line and developed new codes, or assigned already established codes to the text; I compared information from the data collected to the emerging categories. To organise and manage the data, I used the qualitative data analysis software, ATLAS.ti. After having done the

coding for the first five patients I made an appointment with Doctor Archer, who had presented the workshop on ATLAS.ti, to check with her my understanding of the coding of the text and my approach to the research. I furthermore met my supervisor on a weekly basis to discuss the research process and problematic issues stemming from the research.

I then read all the transcriptions again, generating 521 codes. By carefully reading through the codes again, I checked the codes and reduced this number to 338 codes by merging codes that were duplicates or renaming codes where appropriate. Rereading material also served the purpose of mulling over the data and allocating new codes to previously read data.

The next step for me was the categorisation of phenomena, of creating families of codes. When codes are meaningfully grouped together, the groupings are known as themes, which are called families in ATLAS.ti (Archer 2012). In this process of linking, categories are integrated and refined (axial coding). This was also not a linear, but rather a circular process that already started with the creation of families in October 2013. Through mulling over ideas, linking and integrating categories, I developed several versions of families of codes, until the seventh version or model was accepted by me and my supervisor.<sup>3</sup> The central or core category in this model, the red line or bar running through all the other categories, is the therapeutic relationship.<sup>4</sup> These models are my efforts to create a story line, a visual representation of the relationship between the different categories.

Following the model of abductive inference, I integrated the findings of the study with my perspective and experience and with existing knowledge and theory. In a case study, data analysis involves a description of the case. Themes or issues that have been uncovered can be described and be presented as a theoretical model (Creswell 2013).<sup>5</sup>

---

<sup>3</sup> See Section 3.3.

<sup>4</sup> See Section 9.5.

<sup>5</sup> See Chapter 9.

### **2.8.7 Representing the data: writing up**

Different writing styles can be used to represent research. In the scientific writing style, more closely related to the positivist research tradition, a more impersonal style is used, whereas qualitative writers, according to Eriksson and Kovalainen (2008), allow themselves to be more present in their writing. They, for example, use vivid descriptions to carry meaning and to hold their readers' attention. Creswell (2013) writes that the narrative forms used these days in qualitative research are extensive and that qualitative researchers are today much more self-disclosing about their writings. According to him it is no longer acceptable to be the omniscient, distanced qualitative writer.

Richardson (2005) writes that writers do not have to play God claiming universal knowledge; they "still have plenty to say as situated speakers, subjectivities engaged in knowing/telling about the world as they perceive it" (Richardson and St. Pierre 2005: 961).

It is furthermore important to keep the intended audience in mind. For an academic audience a coherent structure that links the research to existing theory is important. Reports should include a detailed description and explanation of the methods and the manner the study was done, the reasoning of the researcher and the analytical process (Fossey et al. 2002; Delpont and Fouché 2011). It can however be difficult to reproduce the complexity and richness of qualitative research within a report following a conventional structure (Eriksson and Kovalainen 2008). This can be addressed by representing the real world of those studied, by allowing participants' accounts to be visible through, for example, appropriate quotations and thereby bringing the reader as close as possible to the experiences being described (Fossey et al. 2002; Delpont and Fouché 2011). The writing up will also reflect on the challenge of integrating everyday experience with scholarly abstract concepts.

In this study I used a more personal, realist style in which the voices of the patients are given space. I used many quotes, since these not only provide evidence, but also inject a certain liveliness; the quotes make the patients more 'real'. I also attended to a coherent structure with a detailed description of the research process.

## 2.9 STRATEGIES TO ENSURE QUALITY

Criteria used in quantitative research have to be abandoned in qualitative research, since observation, analysis and interpretation are bound to be subjective (Bergman and Coxon 2005). “Description, explanation, prediction, and the assessment of causes and consequences of social phenomena cannot be achieved in the absence of evaluation and interpretation. To understand is to interpret” (Bergman and Coxon 2005: 2). To capture ‘external’ reality, observations have to be translated into subjectively interpreted and context-bound realities (Bergman and Coxon).

Eriksson and Kovalainen (2008) echo this and write that conventional criteria used to assess quality of research stem from a positivist stance in quantitative research and include the concepts of validity, reliability and objectivity. Validity in quantitative research means “that the test or instrument you are using actually measures what you need to have measured” (Delport and Roestenburg 2011: 173-174). Reliability refers to being dependable and “occurs when an instrument measures the same thing more than once and results in the same outcomes” (Delport and Roestenburg 2011: 177). These constructs are however regarded as unsuitable to establish the value of qualitative research.

This led to Lincoln and Guba (1999) proposing four alternative constructs to assess the quality or trustworthiness of qualitative research:

- i. *Credibility or authenticity*: The research has to be conducted in such a way that the subject has been accurately identified and described. The participants’ view has to match the researchers’ reconstruction. Steps to increase credibility are prolonged engagement and persistent observation in the field, triangulation of different methods and formalised qualitative methods such as grounded theory.
- ii. *Transferability*: Can the findings of the research be transferred from a specific situation to another? The generalisation of qualitative findings to other populations is often seen as a weakness of this type of research, but triangulating multiple sources of data can enhance a study’s generalizability.

- iii. *Dependability*: Is the research process logical, well documented and audited? This is the alternative to reliability. The interpretive assumption is that the social world is always being constructed and the concept of replication is itself problematic.
- iv. *Confirmability*: Can the findings of the study be confirmed by another study? Does the researcher provide evidence that corroborates the findings and interpretations by means of auditing? (Schurink et al. 2011).

Credibility is an alternative to internal validity, transferability to external validity or generalizability, dependability to reliability, and confirmability an alternative to the traditional concept of objectivity (Schurink et al. 2011).

Qualitative researchers have become increasingly uncomfortable with these criteria developed by Lincoln and Guba (1999) and argue that it is unfair to use criteria based on positivism to assess qualitative research (Nieuwenhuis 2007; Schurink et al. 2011). The notion of management of the research process, transparency of the auditing trail (what was discovered and how was it discovered) and reflexivity have become important strategies for ensuring quality in research. The postmodern trend in qualitative research is to encourage a constant 'reflexivity', that is for researchers to undertake a continuous critical analysis of their thinking and feeling concerning the research process (Schurink et al. 2011).

Bergman and Coxon (2005) write that data is nothing but interpreted observations, and our findings are thus strongly dependent upon what we accord the status of data. The data will be influenced by factors such as question phrasing, probed responses, and non-verbal cues; researcher and participant may also understand the questions in different ways. To enhance the quality, the subjective evaluation and judgment needs to be made as explicit as possible to make the research process more coherent and convincing. The explicit description of research steps allow an audience to judge the plausibility of a particular study and its findings.

Creswell (2013), in discussing quality of research, asks two questions: Is the account valid and by whose standards? And: How do we assess the quality of qualitative research? He considers 'validation' in qualitative research to be an attempt to assess the 'accuracy' of the findings, as best described by the researcher and the participants (Creswell 2013).

For him validation implies a process and he recommends that validation strategies be referenced. Reliability can be enhanced by good quality tape recordings that are accurately transcribed. The coding process also needs to be checked. In my study, my supervisor went through four interviews that I had coded to check whether she agreed with the way I did the coding.

Creswell and Miller (2000) define nine procedures commonly used for establishing validity in qualitative research:

- I. *Triangulation*: Researchers search for convergence among multiple and different sources of information.
- II. *Disconfirming evidence*: A search for disconfirming or negative evidence.
- III. *Researcher reflexivity*: This refers to the researcher reporting on personal beliefs, values or biases that may shape their inquiry, to then bracket or suspend those biases as the study proceeds.
- IV. *Member checking*: Data and interpretations are taken back to the participants so that they can confirm the credibility of the information and narrative account.
- V. *Prolonged engagement in the field*: Trust is built and evidence solidified.
- VI. *Collaboration*: Involving participants by building their view into the study.
- VII. *The audit trail*: Clear documentation is provided of all research decisions and activities. An external auditor can then examine both the process and product of the inquiry.
- VIII. *Thick, rich description*: The setting, participants and themes are described in rich detail.
- IX. *Peer debriefing*: The review of the data and research process by someone who is familiar with the research or the phenomenon being explored.

In a later book, Creswell (2013) describes eight of these validation strategies and ends by recommending that qualitative researchers use at least two of them in any given study.

Creswell, however, writes that other criteria apart from validation are useful in evaluating the quality of a study. He mentions specific criteria that can be used according to the approach to qualitative research. For example, in a grounded theory approach Creswell (2013: 262) will look for:

- The study of a process, an action, or an interaction as the key element in the theory.
- A coding process that works from the data to a larger theoretical model.
- The presentation of the theoretical model in a figure or diagram.
- A story line or proposition that connects categories in the theoretical model and that presents further questions to be answered.
- The use of taking memo's throughout the process of research.
- A reflexivity or self-disclosure by the researcher about his or her stance in the study.

In addition, Creswell's criteria for evaluating a good case study include (Creswell 2013: 265):

- Is there a clear definition of the "case" or "cases" in the study?
- Is the "case" (or are the "cases") used to understand a research issue or used because the "case" has (or "cases" have) intrinsic merit?
- Is there a clear description of the "case"?
- Are themes identified for the "case"?
- Are assertions or generalisations made from the "case" analysis?
- Is the researcher reflexive or self-disclosing about his or her position in the study?

Still on the topic of assessing the quality of qualitative research, Denzin and Lincoln (2005: 5) write: "Objective reality can never be captured. We know a thing only through its representations. ...However, the use of multiple methods, or triangulation, reflects an attempt to secure an in-depth understanding of the phenomena in question".

Richardson (1994; 2005) argues that triangulation is based on the assumption of a fixed point or object that can be triangulated. She proposes that the concept of triangulation is replaced by the concept of crystallisation. The central image for qualitative research should not be a triangle, but rather a crystal. Crystallisation is the process of seeing an emerging pattern in the infinite varieties of shapes and transmutations. Reality emerges from the various data gathering techniques and data analyses employed. "This crystallised reality is credible in so far as those reading our data and analysis will be able to see the same emerging pattern, and this adds to the trustworthiness of our research" (Nieuwenhuis 2007: 81).

In Chapter 10, I discuss the strategies that I used to enhance the quality and trustworthiness of this study.

## **2.10 SUMMARY OF CHAPTER 2**

In this chapter, I described qualitative research as research approach. I followed this up with a description of my research philosophy and the place of literature and theory in qualitative research. I then discussed grounded theory and the analytic procedures used in the coding process of grounded theory. This was followed by a description of deductive, inductive and abductive reasoning.

Then I discussed research ethics. This was followed by a discussion of my research design and answering the question about what a case study is. Research methodology followed and I ended with strategies to ensure quality.

## **SECTION 2**

### **THE FINDINGS**

**In this section:**

**Chapter 3: Introduction to the findings**

**Chapter 4: The hospitalisation process and initial experiences**

**Chapter 5: Holding and containment - or the lack thereof: The primary factors**

**Chapter 6: Holding and containment - or the lack thereof: The secondary factors**

**Chapter 7: The therapeutic relationship: A possibility awaiting realisation**

### **3 INTRODUCTION TO THE FINDINGS**

#### **3.1 ADMISSION TO WESKOPPIES HOSPITAL**

South Africa is divided into nine provinces. The smallest province, Gauteng, a Sesotho word meaning 'place of gold', covers only 1,4 per cent of South Africa's land area, but is home to over 12 million people (SouthAfrica.info 2012).

Weskoppies Hospital (WKH) is situated in Pretoria, the capital of South Africa that lies in the northern part of Gauteng. The name Weskoppies means 'the hills to the west', since, when the hospital was established in 1892, it was lying to the west of the city, although with time it has been engulfed by the rapidly expanding industrial areas and suburbs.

The hospital is situated in a large attractive parkland, but a lack of funds limits the upholding of the facility and the gardens. These financial constraints also at times impede the service delivery to the patients, including the delivery of medication and catering. WKH is classified as a specialised psychiatric hospital and is a training hospital for the University of Pretoria. Such specialised hospitals, as well as other tertiary hospitals, are linked to specific universities, but are government run public hospitals, which creates problems since the training of under- and postgraduate students has to be balanced with service delivery to patients. Since the state sector is underfunded and undersupplied in terms of finances and staff, this puts enormous pressure on these hospitals.

Psychiatric patients living in Northern Gauteng can be referred to WKH and admitted as voluntary, assisted, or involuntary patients for care, treatment and rehabilitation as stipulated in the South African Mental Health Care Act No. 17 of 2002. Twenty years ago the hospital had about 1500 patients; many of these were chronic patients in need of permanent care and housing. Policy changes brought about the discharge of these chronic patients and at present the hospital accommodates about 500 patients. Most of these are patients hospitalised for acute psychiatric problems, although there is also a forensic unit with closed wards for state patients with problems, for which long-term care and treatment are required.

Towards the hill there are several old wards, built more than a 100 years ago and declared national monuments. These old wards are very beautiful buildings, although only one is in a reasonably good condition. Between these wards and Central Admissions is a long block

of closed wards. They are new, clean wards, but the layout reminds one of a prison. Inside they display a harshness and coldness. To the western side of this block there are additional open wards, but, although newer, they are not as inviting as the old wards lying towards the hill. In-between these wards lie a soccer field and parklands – large grass fields under huge trees.

The first contact for a patient to be admitted to WKH will be at Central Admissions, a new building which hosts administrative staff and has also offices for the registrars and nursing staff on duty. After the administrative work has been done, a patient will be interviewed by the registrar, usually accompanied by senior medical students. The patient is then seen by the nursing staff, who documents the necessary observations, before being escorted to the designated ward. Patients are usually admitted to open wards, but assisted or involuntary patients may be admitted to secure, closed wards if there is a risk of harm to self or others. They are then transferred to open wards as soon as their psychiatric status has been stabilised.

Patients are admitted to a specific team according to their diagnosis, e.g. to the Team for Mood and Anxiety Disorders. The admitting registrar might not always be the treating registrar; who that will be is decided the next day by the treating team. The treating registrar is supposed to see his or her new patient as soon as possible, but due to several factors such as a high workload, this might happen only a few days later. This is obviously an unfortunate situation, because although the patient will be looked after by the nursing staff, the doctor is the central figure for a patient. (This is initially the case in any hospital - in later chapters, it will be shown that someone else might become the central figure in a psychiatric hospital.)

In Table 4 the structured weekly programme of the Friday Team's registrars, with their typical academic activities included, is given as an illustration of the tight schedule of the five teams.

**Table 4: The structured weekly programme of the Friday team’s registrars, academic activities included**

<b>Mo</b>	8h30 - 11h00 MDT meeting		
<b>Tue</b>	8h30 - 11h00 Ward conference		
<b>Wed</b>	8h30 - 11h00 Ward conference	12h00-13h00 Journal club	13h30-15h00 Neuropsychiatry
<b>Thu</b>	8h00 - 15h30 Out-patients		13h00 - 15h30 Academic meeting with HoD (if finished with the out-patient clinic)
<b>Fri</b>	On call the whole day		

A registrar has to see his or her inpatients in-between this structured programme. The time for inpatients is thus quite limited and registrars at times have to stay after hours to see all their patients.

After having been seen by the registrar, the patient will be referred to the other disciplines that are part of the multi-disciplinary team - psychologists, occupational therapist and social worker. WKH has only one pastoral counsellor; patients will be referred to him on request or if the team deems it indicated. All patients are discussed by the whole team on a weekly basis. Each team has also two ward conferences per week were a patient is presented in depth to all the team members. Medical, psychology, occupational therapy and nursing students attend these conferences.

## 3.2 THE PARTICIPANTS

### 3.2.1 Brief clinical summary of research participants

Patients interviewed for this study were selected from the different teams as described in Chapter 2 and from various open and closed wards. Table 5 gives a summary of the patients interviewed; also listed are the document numbers (P1, P2, etc.) of the transcriptions made of the interviews.

**Table 5: Brief clinical summary of research participants**

Doc no	Pt no	Patient	Patient information	Diagnosis
P1	1	First interview with A	A is 44 years of age and lives in Pretoria in a middle class environment with his wife and two children. He finished matric, but dropped out of university. He then worked for a motor company for 18 years, but took a package in 2008. At present he helps his wife to run a doggy parlour. At the time of the first interview he was already hospitalised for two months in a closed ward, but was much improved and euthymic. He is a friendly person of average build. Several previous admissions.	Bipolar I disorder, current episode manic, severe with psychotic features (on admission)
P2	1	Second interview with A		
P3	2	First interview with O	O is 34, his highest qualification is Grade 7 and he lives with his mother in Mpumalanga. He was in WKH for four months already and stable. He is slightly built, was friendly, but unsophisticated. First admission.	Bipolar I disorder, current episode manic, severe with psychotic features (on admission)
P4	3	First interview with I	I, a 54-year-old coloured woman, originally from the Northern Cape, now lives in Tembisa (near Johannesburg) with her husband and speaks Sotho with her three children. She left school in Grade 9 and worked previously as a domestic worker, but is now unemployed. She is of slight build and a soft-spoken, shy person. First admission.	Adjustment disorder with depressed mood
P5	4	First interview with J	J is 32 years of age; he finished matric (Grade 12) and sells insurance policies. He is not married, has no children and lives with his mother and siblings. Admitted seven weeks ago, but still in a closed ward although at this stage apsychotic and euthymic. J was very friendly with a warm smile. First admission.	Bipolar I disorder, current episode manic, severe with psychotic features; substance abuse
P6	4	Second interview with J		
P7	4	Third interview with J		
P8	1	Third interview with A		
P9	5	First interview with AI	AI, 57 years of age, has three children out of her first marriage and lives in a poorer suburb with her second husband of 29 years. Her highest qualification is Grade 10 and she has never worked. She is slightly overweight and	Bipolar II disorder, current episode depressed

Doc no	Pt no	Patient	Patient information	Diagnosis
			presented with a slightly blunted affect. First admission.	
P10	5	Second interview with AI		
P11	6	First interview with Jo	Jo is 62 and a qualified engineer. He was divorced in 2003, has three children, and has lost his job and home. His psychiatric factors played a major role in this. He is an intelligent person, can be forceful, but was engaging and enthusiastic during the interviews.	Major depressive disorder, recurrent, severe (on admission)
P12	6	Second interview with Jo		
P13	7	First interview with R	32, busy divorcing, has two children and is studying law (2. year). Before admission she lived with her husband.	Borderline personality disorder, substance abuse
P14	8	First interview with Gr	34-year-old Nigerian nursing sister, single, little support. Lives in a shelter in Pretoria. Very outspoken and loud. Overweight. Still signs of psychosis.	Schizophrenia
P15	9	First interview with GI	32, his mother died when he was young, unstable life, lives in a low-class accommodation, jobless. Still psychotic.	Schizo-affective disorder, bipolar type, drug abuse
P16	10	First interview with Lu	A 25 year-old man, jobless, who stays in a shack outside of Pretoria. He has only finished Grade 2 and gives also the impression of someone with below average intelligence.	Substance-induced psychotic disorder
P17	11	First interview with K	24, single, staying with parents in Pretoria, studied law, wants to continue studies in drama. Several months in WKH. An intelligent young man with interpersonal and family problems.	Substance-induced psychotic disorder
P18	12	First interview with Lo	30, single, personal assistant, studying for her master's degree in the arts. Stays on her own in a flat in Pretoria. An intelligent, friendly young woman. Overweight. Stable and euthymic.	Bipolar I disorder, current episode manic (on admission)
P19	13	First interview with E	46, coloured, lives with her mother in Pretoria. Completed a BA degree in the arts in 1996. Gets a disability grant. Slender build, friendly, often smiling and laughing. A patient of WKH since 1989.	Bipolar I disorder, current episode manic, severe (on admission)
P20	13	Second interview with E		
P21	14	First interview with T	About 50, lives with her 4 <sup>th</sup> husband, daughter and grandchildren north of Pretoria. Had several jobs. Overweight, affect slightly blunted. Diagnosed with bipolar disorder 25 years ago.	Bipolar II disorder, current episode depressed
P22	15	First interview with Ac	43, lived with her husband and two boys in Pretoria; marital problems, husband moved out, but they are still trying to sort out their problems. Was a flight attendant. Calm, friendly person of average build.	Substance-induced mood disorder, substance dependence (sleeping tablets)

I interviewed 15 patients. If it was deemed necessary, a second or even third interview was held and recorded. In total 30 interviews were held. Field notes were taken of all

interviews, but only 22 were sent for transcription, because the others did not contain any new information, or I was able to make a short summary of the salient points.

### **3.2.2 Profile of the research participants**

The South African Government continues with the practice of race classification, requiring information on classification (African, Coloured, White and Indian) developed by the apartheid regimen, although the reasoning now is to implement and monitor racial redress (Erasmus 2010). Because this being the official stance, I followed it in the description of the research participants. I compiled the descriptions of the patients from my field notes.

The first patient, 'A', was an intelligent middle-aged man who initially studied engineering at university, but did not complete his studies. He had been admitted several times over the last couple of years; his lack of insight and problems around compliance contributed to this. It was a sad situation and I felt very sorry for him and his family; when he becomes psychotic this friendly man can make life very difficult for his wife and two small children. He was eager to see me, shook my hand and said he had dated a girl with a similar surname when he was young. He wanted to make contact. For the first interview I saw him in the closed ward, where he already had been for two months. The next day he was transferred to an open ward, where I saw him for two more interviews. We made good contact, until at the end of the last interview he asked me my opinion about his further treatment. When I emphasized the importance of medication I could sense a certain distance developing between us. He still believed God has healed him. What stood out for me were his feelings of helplessness in the closed ward, of not having the power to change anything and just having to wait. Reading my field notes several months after I had written this, I was again struck by the eagerness he displayed to make contact with me. Another thing that stood out was that, for him, the social worker was the most important person – the team member who did not rotate and who had accompanied him and his family for many years.

The second patient, 'O', was an uneducated man who made a child-like, naive impression. The OT described him as low functioning. In his child-like way he was grateful and

satisfied with everything; the information I got from him was otherwise limited. He was also very friendly and made good eye contact. I had the impression that he was eager to talk to me, similar to the first participant. During the first interview with him I decided to not see him again as initially planned. He however reminded me that I had promised to see him again and I thus went back to his ward the next day. He was really pleased to see me and thanked me for coming.

'I', the third patient, was a gentle, slightly timid and introverted person. She lost her work as a domestic worker after a bus accident in 2008. Although her husband is employed, the family struggles financially. This, and the alcohol abuse of her husband, became too much for her and led to the admission. She was very grateful about the help received, but found my questions exhausting towards the end. My impression was that she felt nervous about giving right or wrong answers. In my field notes I had written that the notes made in her file by the registrar were also mostly limited to present symptoms and medication, with little about her personal history.

'J', the fourth patient, was someone I looked forward to seeing again. He was open, pleasant and friendly. On admission it was stated in his file that he was psychotic and he was placed in a closed ward. Aggressive, inappropriate behaviour was noted for the next 10 days, but for the last two to three weeks he was described as a psychotic and stable. What struck me was that he had no knowledge about the MDT and its different members, having only seen the registrar. Thought provoking was also his very positive experience of the nurses-in-training. For the third interview he went with me to an office outside the closed ward, but calmly returned with me to again be locked up when we had finished. He was always smiling and friendly and my impression was that he enjoyed talking to me. When thinking about his treatment and his long stay in the closed ward (a total of seven weeks) it needs to be kept in mind that there were at that stage about 90 in-patients allocated to the team treating him (patients suffering from psychotic disorders of whom most also abuse substances). Although the team had three registrars, the workload was still very high. Yet, was it necessary for him to stay in a closed ward for seven weeks? No, and it was fellow patients who made it bearable for him.

Another thought provoking episode occurred with J's new registrar. It was the time for the four-monthly rotation of registrars and I spoke to J's new registrar about his need for

psychotherapy and about a transfer to an open ward. When I followed up on our discussion, I learned that this registrar had thought it in order to continue to keep J in the closed ward over the weekend. It was only on my intervention that J was transferred to an open ward the same week. Why did an experienced and empathic registrar not transfer him immediately? To me it showed how we become blunted towards the patients' difficult experiences and how we use denial, amongst other defence mechanisms, to not acknowledge the stressful reality of the patients and to cope ourselves with a difficult situation.

The fifth patient, 'Al', looked older than her 57 years. Her husband was physically not well; a serious stressor to her. She was a withdrawn person who did not engage easily. Although she was slightly anxious, she made good eye contact and answered all questions in a straightforward manner. She had been in the hospital for one month, but said that she felt worse. The treating team had planned to start ECT because of her severe depression and lack of response to medication, only to find out that the anaesthetist was on study leave. The hospital has the service of only one anaesthetist, who is in private practice and holds a session post at WKH. It had been a huge challenge for the hospital to find an anaesthetist willing to give anaesthesia for ECT and there was no one standing in for this one anaesthetist. This is an illustration of the many challenges we regularly face in WKH and which obviously affect both patients and staff. The patient's situation was further complicated by the fact that her registrar was writing examinations and the other registrar of the team stood in for her. What I find amazing is that the patient did not mention the problems around ECT or the change in registrars in the two interviews I had with her; in the second interview she complained only about a disruptive fellow patient and also about the conflict in general between the nursing staff and patients. She was furthermore apologetic about being so tearful.

'Jo' was the opposite: engaging, enthusiastic and appreciative of the help he had received, although slightly idealising the registrar. The registrar, however, had spent a lot of time with Jo, so a positive response was very understandable. He seemed to be hungry for talking and communicating. Jo also enjoyed walking on the big terrain and looking at the old wards which are national monuments. This was one of only two participants who had a very good therapeutic relationship to their registrar, which mostly had to do with the registrar being interested in the personal history of the patient and taking time to listen to

the patient. This patient also described how patients are observant of the body language of a doctor and how this can negatively affect a patient.

'R' was an intelligent 32-year-old woman, with an inner instability, which was not helped by her going through a divorce. She was generally more critical of the situation in the ward and the attitude of the staff. In the interviews she was initially negative and distrustful, but this changed and she gradually became more open and relaxed. She had also spent two weeks in a closed ward.

'Gr', the eight patient, was a very gregarious, loud person. She was a nursing sister and a foreigner to this country. Although her circumstances were very difficult, she seemed full of life. She was diagnosed with schizophrenia, still suffered from psychotic symptoms (delusional interpretations of happenings in the referring hospital), but was coherent in the interview. Our interview was in an open ward, but she had initially been admitted to a closed ward for six weeks. She was of opinion that seeing a patient once a week was not enough and that increasing this to two, or rather three times a week, would shorten the stay of patients in the hospital. According to her, the dress code of the doctors was also not acceptable; patients would trust doctors more easily if they were dressed in 'a corporate way'. Another criticism was that religious or spiritual concerns were not addressed and that doctors showed little interest in, or understanding of, such matters. This, as well as an attitude of rejecting spiritual concerns, led patients to hide these experiences and thoughts from doctors.

'Gl' was a young man with very limited family or other support. His mother had died in a car accident when he was still very young; according to notes in his file his father had driven the car in an intoxicated state. He was uneducated, had no job and still displayed some psychotic symptoms. When I initially interviewed him he indicated that he understood what the research was about and was able to give informed consent. He was friendly and smiling, but towards the end of the second interview he became hurried, slightly guarded and at times tangential and illogical. (His name was given to me by both the registrar and consultant psychiatrist of the team as someone who could participate in my research.) This was his 8<sup>th</sup> admission; he had threatened his family, and was now, a month later, still in a closed ward. According to him, he had been beaten in the ward,

something I was not able to confirm, but I did discuss this with his registrar and consultant psychiatrist.

'Lu' was another young man, jobless and homeless, a situation ripe for substance abuse, the cause of his psychosis. His low IQ was a further contributing factor to his severe problems. He was friendly, likeable and very accepting of the situation and treatment received, even though he had already spent three months in a closed ward. He stayed this long, since the team had had problems tracing his family, but he was to be discharged the following day. I thought it was important to also hear his voice in my study.

'K', on the other hand, was a young, intelligent black man growing up in a middle class environment. He had already spent ten months in the hospital, the first four months in a closed ward. K said that he was very ill on admission and only stable after three months in the closed ward. His mother had died when he was two years of age and his father had later remarried. This was already his 6<sup>th</sup> psychiatric admission. Because of conflict in the family the team tried to arrange temporary accommodation away from home; this had contributed to this length of stay. His intrapsychic, interpersonal and family problems were factors hampering him in making use of his resources and he had stopped his studies. He is however young and plans to study drama. Hopefully he will succeed this time. In the interviews he was friendly, articulate and cooperative. I again had the impression that there was no therapeutic relationship between him and his registrar. He valued OT, especially the creative activities.

'Lo', the twelfth patient, was a young, dynamic black woman with many opportunities. She held a good job and was also studying for a master's degree in psychology. Living alone in Pretoria with her family being far away made things difficult for her, especially when her boyfriend left her, because of her mental problems, during her present admission. She felt extremely lonely in the hospital.

The first interview was in a closed ward; she was friendly, easy to engage with and found the interview interesting. This, as well as her studying psychology and ability to reflect on her experiences, made her a valuable contributor to this study. When I came to the ward a few days later to the ward she eagerly asked: "Are you here to see me?"

Lo said that she preferred seeing only one person working on her or his own, e.g. her referring psychiatrist, instead of one person being part of a team. She felt that would strengthen the therapeutic relationship; the team furthermore limited the 'power' of the doctor or registrar to make decisions.

The second interview was held in an open ward, shortly after her transfer there. She welcomed the freedom of the open ward, but was worried about two patients who had absconded and felt that security should be better to prevent such happenings. She again stated that she would prefer to follow up with her private psychiatrist, who worked on her own and not as part of a team (MDT). This, she believed, would lead to shorter hospital stays. Other reasons were, that a woman would understand her better and that the circumstances in the private hospitals were also so much better than in the state facilities.

Lo was quite critical of nursing staff. She said: "My definition (*about the role of nursing staff*) is different from theirs, (mine) is care ...For them it is putting your nose where it doesn't belong, telling confidential issues, babysitting." According to her, nursing staff didn't keep confidential information to themselves.

The 13<sup>th</sup> patient, 'E', was a middle aged unmarried coloured woman who unfortunately has a history of numerous psychiatric hospitalisations for a severe bipolar disorder over a period of more than 20 years. She thus has a wealth of experience with psychiatric care and with different registrars. E is an intelligent, sensitive person who completed a degree in the arts (music) in 1996, but who receives a disability grant and stays with her mother. Our interaction was very easy, she often laughed, and was in general positive about her care, although she described terrible experiences during previous admissions. With her I also had the impression that she was very eager to talk to me. I was struck by her comment that a good therapeutic interaction can be established immediately. (I hesitate to call this a good therapeutic *relationship*). Such a good interaction is triggered by the interaction between psychiatrist or registrar and patient in the first few seconds: Does the doctor show interest? Does he or she radiate a positive energy? Does he or she want to interact with this *person*? Does the registrar take up in conversation something that the patient had said? Does he or she follow the patient's thoughts?

E had had many relapses. According to her, these were caused by severe stressors that she encountered, for example deaths in the family, and never due to her stopping the

medication. The last claim I cannot confirm. I saw her for three interviews, of which the third was not transcribed, but I did make notes. In this interview, she described the registrars as 'reactive' - which means that they react to the patient's attitude: if the patient is negative, they are; if the patient is positive, so is the registrar.

'T', a middle-aged white woman, lived with her fourth husband. I remember her as a somewhat dissatisfied person, although her depression could also have coloured this impression. When I interviewed her she was already six weeks in hospital, but not feeling better. Apart from limited information about her personal history written down on admission, the follow up notes in her file only referred to present symptoms and medication prescribed. She made a lot of negative remarks about the nursing staff, but was very positive about the previous sister-in-charge of that ward. She described this sister as having been able to exert good control over the various problematic situations, including the staff members and patients in the ward.

'Ac', the last participant, was a married coloured woman with serious marital problems. Her parents were critical of her behaviour and abuse of sleeping tablets and she had little support. She was very relieved about the help she received and had an excellent therapeutic relationship with her registrar. She was the only patient to make detailed notes, after I had explained to her the purpose of my research but before our interview, of her experiences in WKH. She was only the second patient who had had a very good therapeutic relationship with her registrar. By opening up a space and listening very carefully to the patient, this registrar managed to get her talking even when the patient initially did not want to talk. I was later told by the staff that the patient had also found the research interview very meaningful.

### **3.2.3 Summary of the interviews and patients**

The interview rooms mirrored the state of mental health in South Africa: only one ward had rooms that were inviting and pleasant to be in. The rooms in the other wards were empty and emotionally 'cold', with our voices echoing off the bare walls.

I saw patients number 3, 9, 10 and 14 only once, the others twice or three times. The 15 patients were in total admitted for 175 weeks, the equivalent of 40 months, or on average nearly 12 weeks per patient. Most of them had also spent a long time in closed wards, ranging from two to 16 weeks. The difficult socio-economic situation in South Africa plays a big role in the management of many patients; whenever possible the teams try to arrange outside accommodation for patients in need and this can lead to longer periods of hospitalisation.

The 15 patients had been seen by twelve different registrars during their present hospitalisation.

In terms of education, there is a huge difference between patients, from a patient having only completed Grade 2, up to patients with university degrees. Their age varied from 24 to 62 years. Two patients still displayed signs of psychosis, the others were much improved or recovered and most were close to discharge.

Eight female and seven male patients were interviewed; seven were black, three coloured and five white. Most patients admitted to WKH suffer from serious mental disorders, reflected in the diagnoses of the participants. Five patients suffered from bipolar disorder type I, two from bipolar disorder type II, one from major depressive disorder, one from schizophrenia, one from a schizoaffective disorder and three from substance-induced disorders.

My impression was that 13 out of the 15 patients were eager to very eager to talk to me. Two patients were slightly guarded.

### 3.2.4 Summary of the distribution of patients in terms of race and gender

A summary is given in Table 6.

**Table 6: Distribution of patients in terms of race and gender**

<b>Race</b>	<b>Female</b>	<b>Male</b>
Black	2	5
Coloured	3	0
White	3	2

### 3.3 MAKING SENSE OF THE DATA: THE DEVELOPMENT OF MODELS OF CONTAINMENT AND THERAPEUTIC RELATIONSHIPS

The data was coded and then categorised into families.<sup>6</sup> I developed several versions of families to try and represent the findings, ranging from 8 to 16 families. I also developed several models in an attempt to get an overview or representation of the data. These models are described here to help the reader in understanding the arrangements of the data and quotes, which will follow, as well as the process of developing these models. The different versions of the models in chronological order of development are:

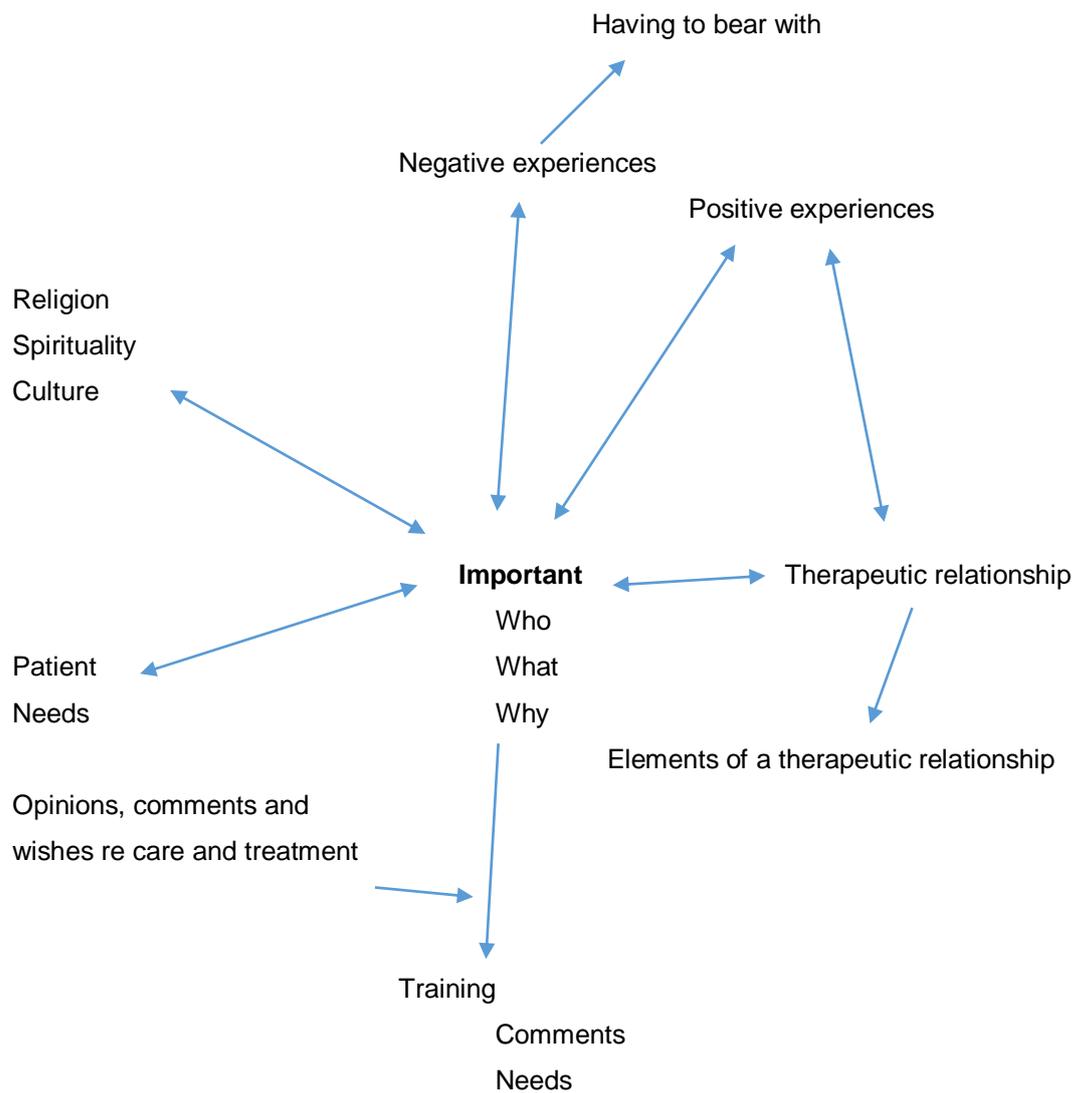
---

<sup>6</sup> See Section 2.8.6.

### 3.3.1 First model: Important relationships in a psychiatric hospital

The first model, depicted in Figure 1, is a description of the different aspects of important relationships in a psychiatric hospital.

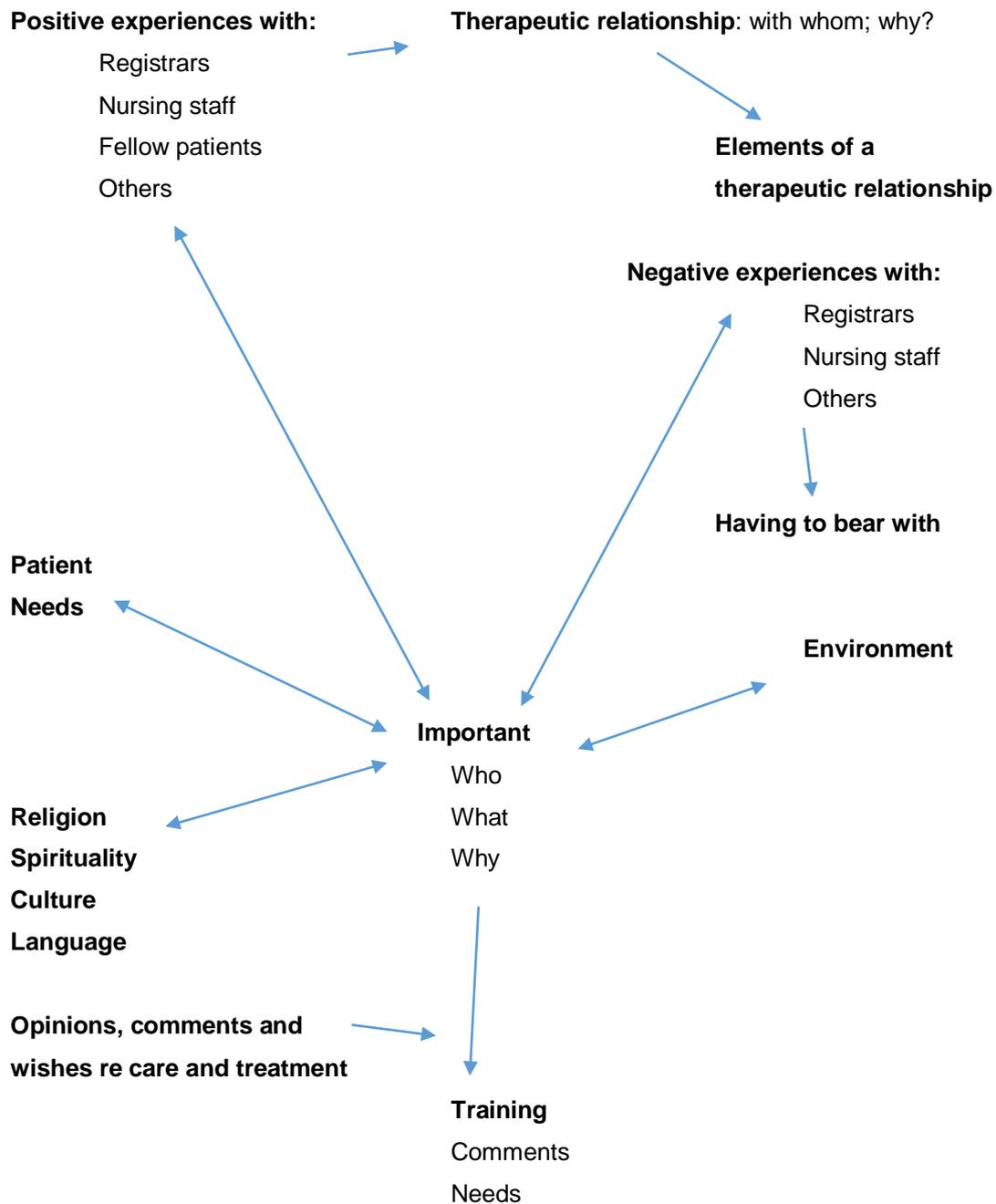
**Figure 1: The first model of important relationships in a psychiatric hospital**



### 3.3.2 Second model of important relationships in a psychiatric hospital

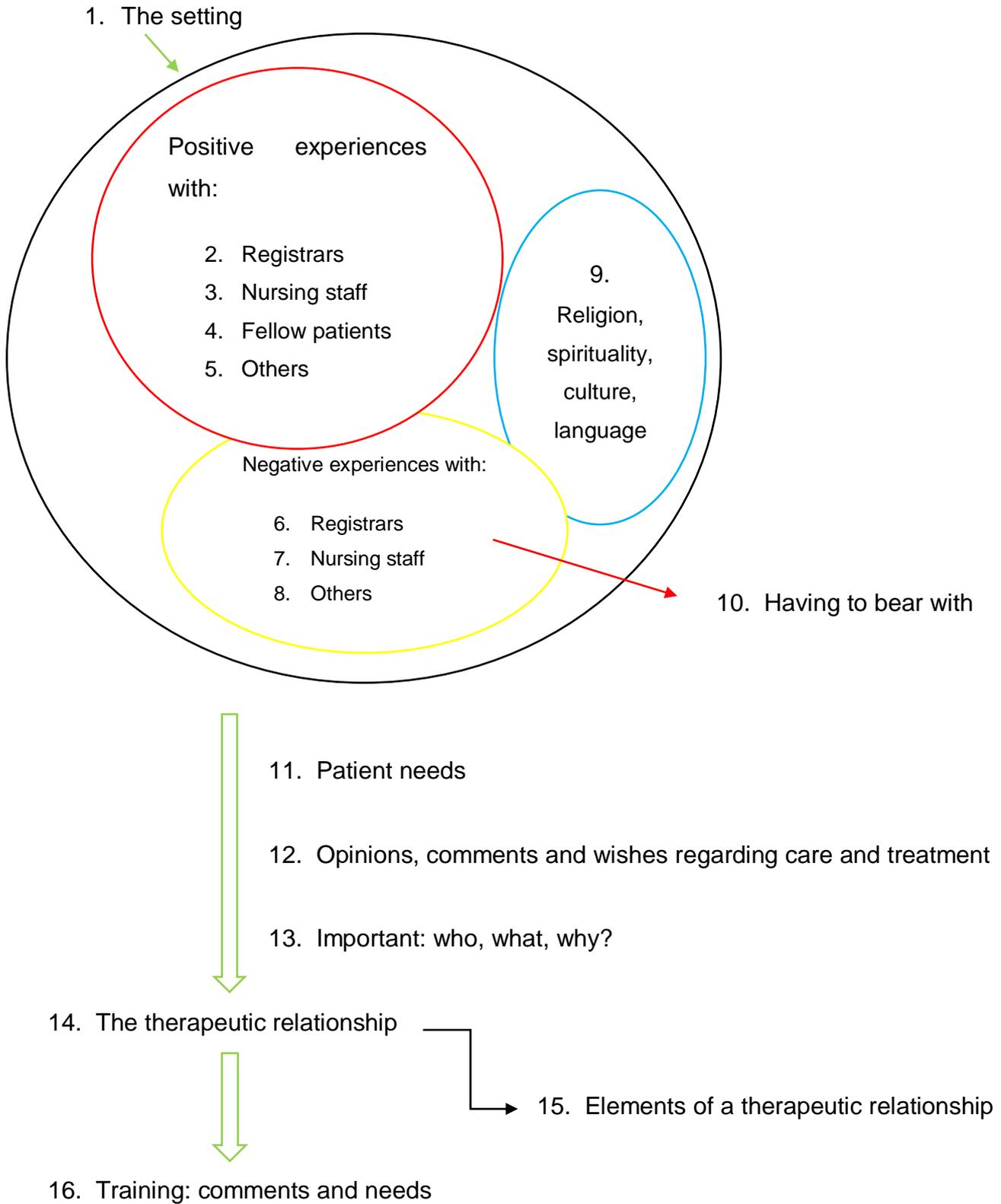
In the second model I dissected positive and negative experiences into experiences with the different team members. I also included the effects of the environment on patients, e.g. being in an open or closed ward.

**Figure 2: The second model of important relationships in a psychiatric hospital**



### 3.3.3 Third model: A setting emerges

**Figure 3: The third model: A setting emerges**



In the first two models the different experiences of the patients are represented and are all related to the central question of what or who is and becomes important to the patients. These were, however, purely descriptive models.

I then realised that I had to think about the setting in which everything happens. The hospital, the buildings, the type of wards, the gardens, the routine and rules form part of this setting. For example, being in an open or closed ward has a huge effect on patients.

In the third model the concept of a setting is therefore introduced and the experiences within the setting take centre stage; from this a flow-diagram emerges ending with training needs.

#### **3.3.4 Fourth model: The concept of containment is introduced**

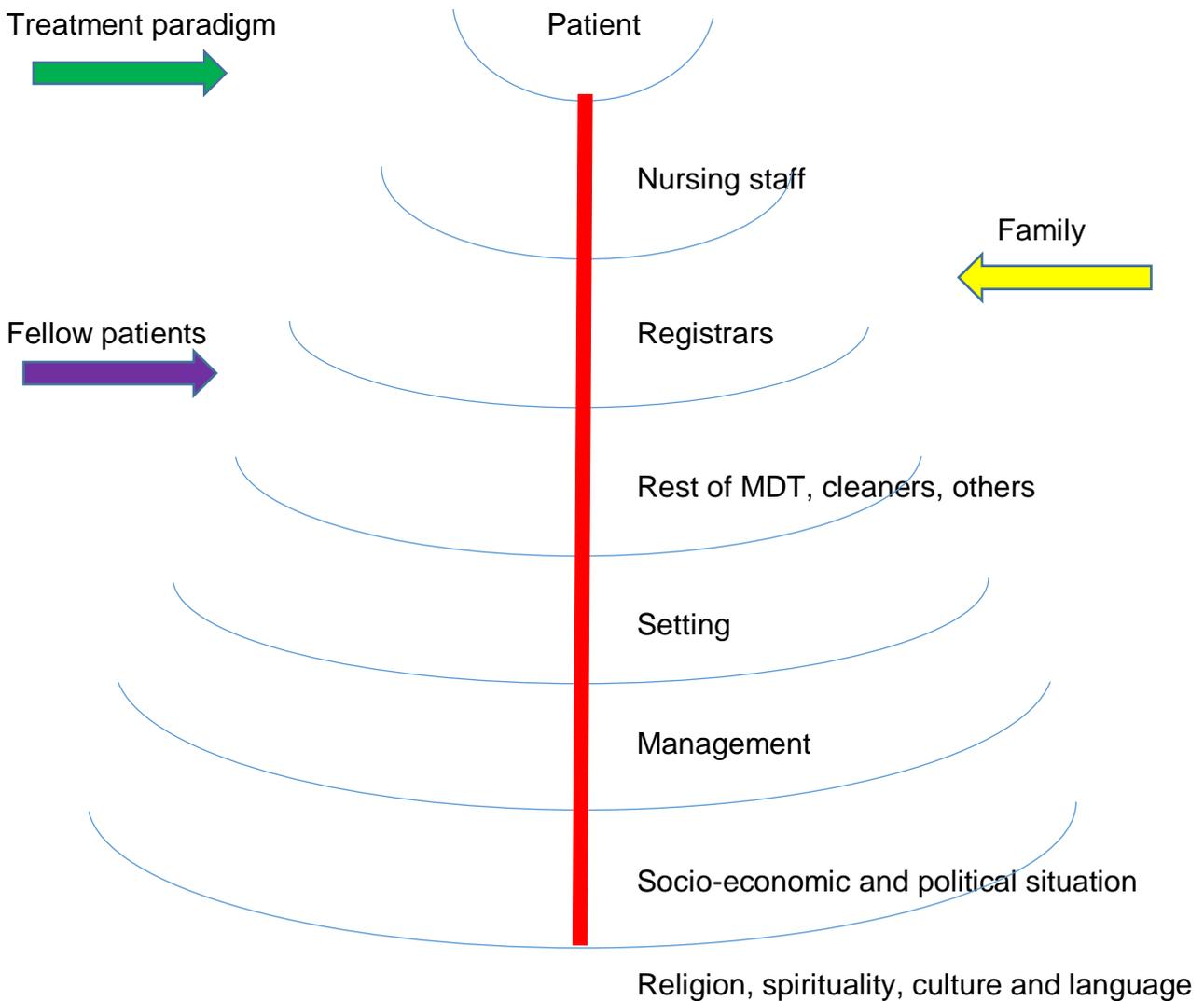
Further reflection on the interviews and information led me to think about the psychoanalytic concept of containment. In the psychoanalytic tradition, containment refers to the idea of providing containment, holding and safety through a therapeutic, personal relationship (Holmes 2010).<sup>7</sup> I was reminded of Casement writing (1985) that the help being searched for by the patient is always for a *person* to be available to help with difficult feelings. The *persons* in the hospital are the determinants of what will happen in the hospital.

The concept of containment became more and more important to me. Not only the patients, but also the different team members need containment to help them cope with their often so difficult work situation.

---

<sup>7</sup> I discuss the psychoanalytic concepts of containment and holding in Section 8.4.7.

**Figure 4: The concept of containment is introduced**

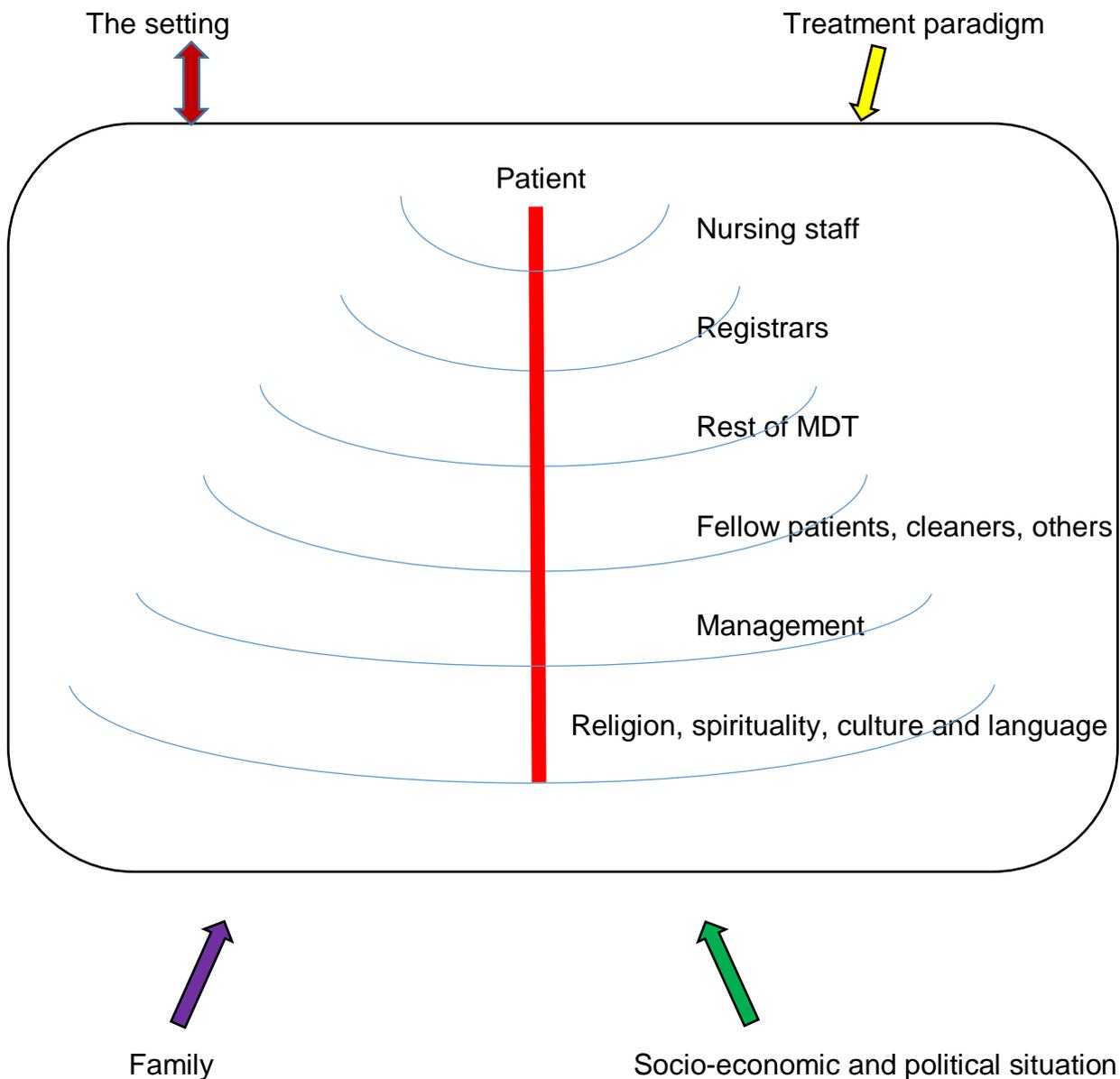


Each concave semi-circle represents the holding or containment provided to the patient on that level, which again rests on a lower level. Nursing staff provides containment to the patients, registrars can provide containment to patients and/or nursing staff, and so forth. The three arrows - the treatment paradigm, fellow patients and family - indicate factors influencing this containing environment. The red bar running through all of this represents the therapeutic relationship, which can be affected by all the different parts of this model.

### 3.3.5 Fifth model: A different way of seeing the setting

I was not satisfied with the placement of the setting as one of the containing rings. In the fifth model I changed this and reintroduced the setting as an encompassing entity. I also added the treatment paradigm as a factor influencing the whole treatment process. The family, as well as the socio-economic and political situation, are seen as outside factors that can influence all aspects of treatment.

**Figure 5: Fifth model: A different way of seeing the setting**



Fellow patients are now seen as part of the containing semi-circles, providing also a possible holding function for other patients. Reflecting on why I previously had left out fellow patients I thought it had a lot to do with recently having had many difficult patients in our ward who abused illegal drugs in the hospital, even smuggling drugs into the ward. Such patients commonly provoke a negative counter-transference in the treating team or psychiatrist. (Counter-transference refers to the reactions and feelings of the psychiatrist towards the patient.<sup>8</sup>) In the previous model I saw patients as influencing the system as such, either positive or negative.

I was however still not satisfied with this model and further discussions with my supervisor led to the development of a sixth model.

### **3.3.6 Sixth model: The hospital as community**

What I previously had described as the setting became now the hospital as a community. In this development I was influenced by Sweet's description of her work as a hospital physician and emphasising the importance of the relationships in a hospital (Sweet 2012).<sup>9</sup>

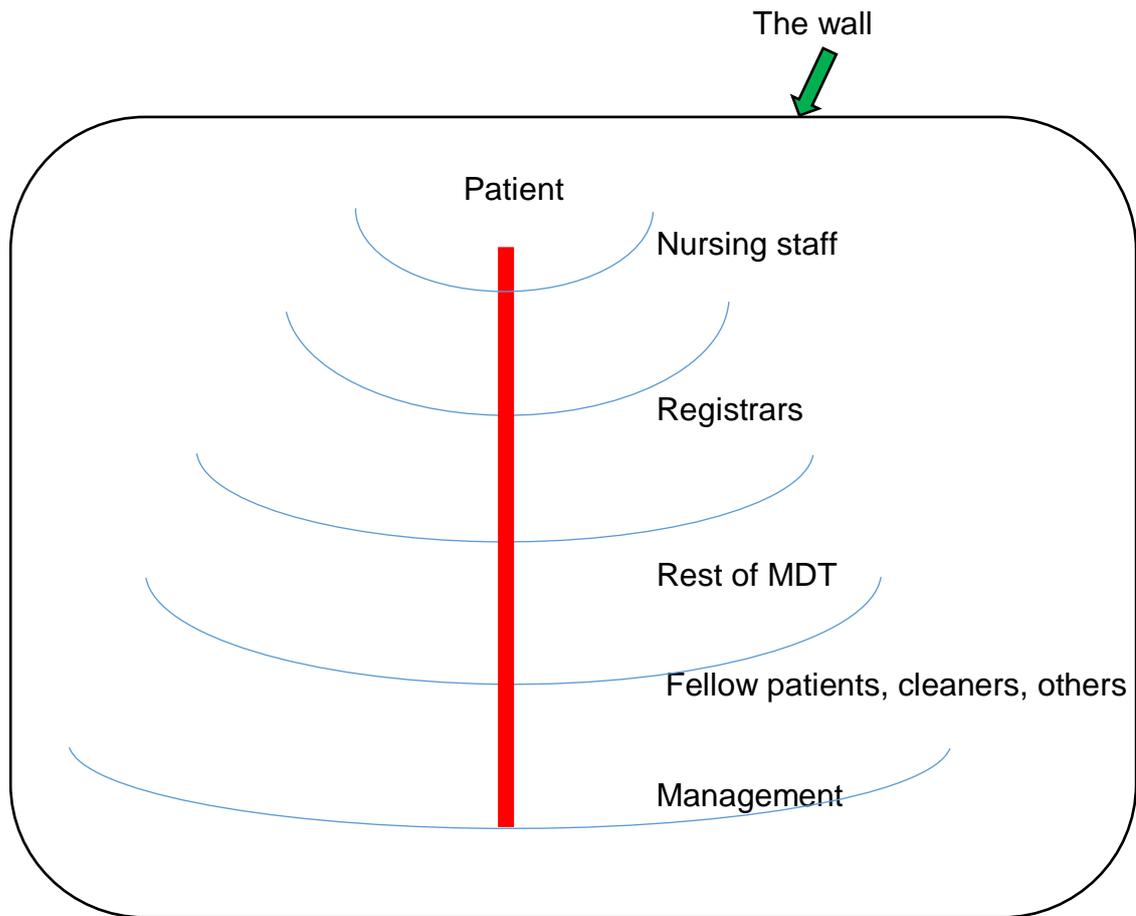
In the sixth model everything encircled (inside 'the wall') represents the community of the hospital; that is all the different people working there (the hosts) and their guests (the patients) (Sweet 2012).

---

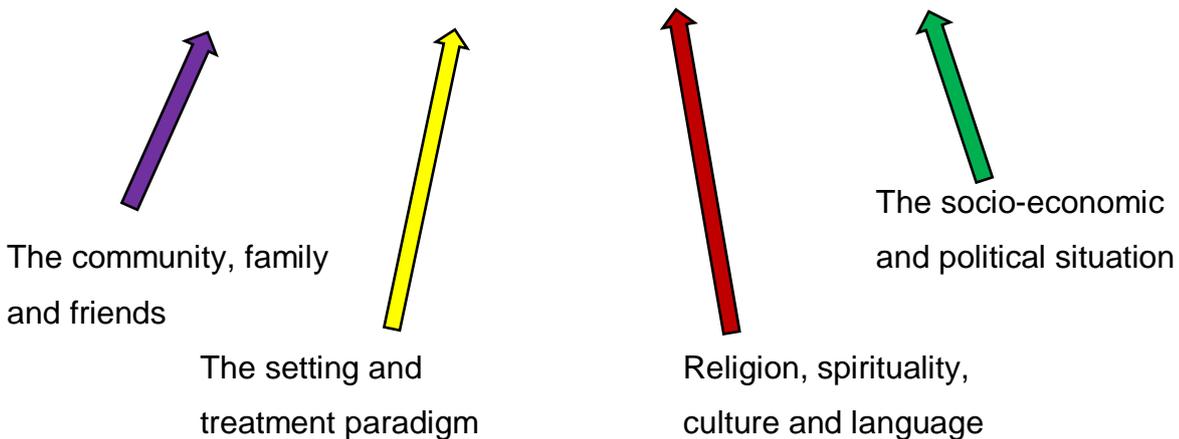
<sup>8</sup> I discuss the concept of countertransference in Section 8.6.5.3.

<sup>9</sup> See Section 8.1.1 for an introduction into Sweet's ideas.

**Figure 6: The sixth model: The hospital as community**



Listed below are the factors impacting on the community, on the hospital.



The family, the setting and treatment paradigm, the socio-economic and political situation, as well as religion, spirituality, culture and language are described as factors that can help

stabilise the hospital situation. Spirituality, for example, can be the most containing factor for some patients and for many religions is the bedrock of their existence. But factors such as the socio-economic situation can also contribute to more stress and a destabilisation, with as a result poor care.

### **3.3.7 Seventh model: The final model of therapeutic relationships**

Still not satisfied I developed a seventh model. I introduced the concept of a frame, in which I included the treatment paradigm, as an encompassing entity. In psychoanalytic thinking the concepts ‘frame’ and ‘setting’ are often used as synonyms (Lemma 2014).<sup>10</sup> I, however, used the concept of a setting to refer more to the environment and the context within which treatment happens. In thinking about a frame, I thought about Gabbard’s writings. Gabbard (2010) writes that psychodynamic psychotherapy operates within a frame that is composed of a set of professional boundaries. Although he also includes the location of the sessions, he describes boundaries (and thus the frame) as “designed to create an envelope within which the therapist can be empathic, warm, and responsive and to establish a holding environment where the patient feels understood and validated” (Gabbard 2010: 60). By using the word ‘frame’ I wanted to refer to these more personal aspects of patient care and to emphasise the role of personal professional relationships in providing help and containment.

Inside the frame a dotted line marks off a subunit representing the MDT and their patients. Each team in WKH, for example the five teams for adult patients, form such subunits.

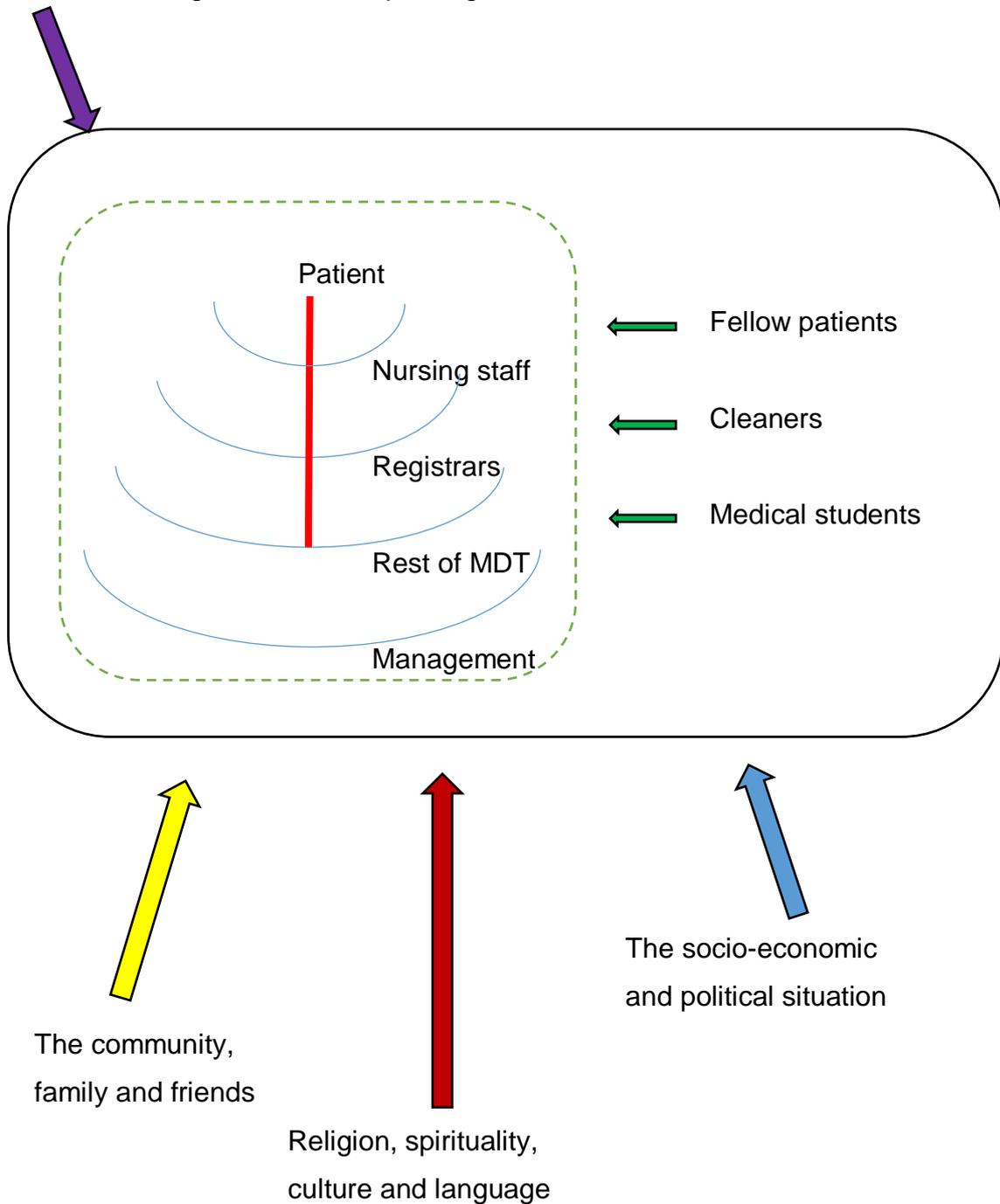
The containing rings are now formed by members of the MDT; management is also included, since they are needed as support to the MDT. Fellow patients, cleaners and medical students are seen as factors influencing the inner circle.

---

<sup>10</sup> See Section 8.6.5.3.

**Figure 7: The seventh model: The final model of therapeutic relationships**

The frame, including the treatment paradigm



The frame and everything inside I described as primary factors and everything outside the frame as secondary factors. In Section 9.5 I discuss the seventh model in depth.

Before that, the patients are introduced through their comments. Their sayings and my findings are organised in the following way:

**Chapter 4:** The hospitalisation process and initial experiences

**Chapter 5:** Holding and containment – or the lack thereof: The primary factors

**Chapter 6:** Holding and containment – or the lack thereof: The secondary factors

**Chapter 7:** The therapeutic relationship: A possibility awaiting realisation

### 3.4 SUMMARY OF CHAPTER 3

I gave an introduction to WKH and the admission process, as well as the 15 patients who participated in the study. To make sense of the data I developed several models to represent the information gathered. In doing this, the concept of containment became important to me. Containment is central to the development of a therapeutic relationship and I discuss it in Chapter 8 (the literature review) and in Chapter 9 (An analysis of the care and treatment offered at Weskoppies Psychiatric Hospital, leading to the development of a model and substantive theory of therapeutic relationships).

Three other important ideas at this stage were:

- i. With the exception of one ward, the wards are cold and sterile. There are no inviting rooms, no decorations, nothing friendly; also no gardens. In short: the environment in and around the wards is not therapeutic. This is in stark contrast to the bigger hospital setting in a big parkland. Being with patients in these rooms, I became very aware of the coldness of the rooms, mirrored in our voices echoing from the empty walls.
- ii. The situation in a psychiatric hospital is extremely complex; it is a huge inter-related system. All of these factors ultimately determine the outcome.
- iii. No patient approached by me refused to participate. On the contrary, they were eager to participate. I remember the eyes of one patient lighting up when she saw

me entering the ward: “Are you here to see me?” I had the impression that they were welcoming personal contact.

The hospital and its parklands have a lot of potential. The old wards are beautiful buildings and could be wonderful wards, but financial restraints severely limit what can be done. Something very unfortunate is, however, the way the closed wards were designed. A visiting doctor actually asked whether the blueprint used in their design was that of a prison.

## 4 THE HOSPITALISATION PROCESS AND INITIAL EXPERIENCES

In Chapters 4 to 7 I present the findings of the interviews with the research participants. In this chapter an overview of the admission process and happenings in the wards from the participants' perspective is given; comments by patients are given and discussed. The quotations are given verbatim; I did not correct any errors of language. Quotes in Afrikaans have been translated or summarised by me and are printed in blue.

### 4.1 CENTRAL ADMISSIONS

First impressions are of great importance. A smooth running admission process can instil confidence; if this is not the case it can lead to uncertainty, as commented by this patient:

*Admission is clean, very nice, nursing staff just needs to be more patient with the patients; they tend to get irritated at times. And at the end I just think that it would be nice if the whole administration process could just go a bit quicker, because the patients start getting impatient and then they wonder: they're here, is it good to be here? And I don't know, I just felt that, you know, I don't want to be here, because we're sitting almost a whole day before I got into a ward. (P22:17)*

Although arriving at Central Admissions in the morning, the patient stated that she was only attended to after several hours and admitted to the ward at about 17h00. She starts off on a positive note: it is "very nice", but then the problems creep in and in the end the patient wonders whether it would be a good thing to be admitted to this hospital – "I don't want to be here". A negative tone is set. How will this influence her treatment? She continues:

*You know they (the sisters at Central Admissions) ask you questions, they make you feel quite guilty for what you've done, ... I'm not saying that I wanted sympathy from them, but the manner in which the questions are asked, it's like you know, if you did this, you abused whatever substance, so you need to be punished to an extent for that, because it's not supposed to*

*be like that. You know, so you feel guilty for what you have done. I mean you already feel guilty for what you have done, but they just make it worse.*  
(P22:146)

It is striking how, within the first couple of hours at the hospital, this patient's attitude changed from positive to feeling guilty and negative – "I don't want to be here..." This really is something very worrying. Because of such early negative experiences, it might be difficult to build a good working alliance with this patient.

## 4.2 HOSPITAL ENVIRONMENT

The hospital is situated in a quiet environment and the grounds are large. Many patients showed appreciation for these peaceful surroundings:

*Ek sê ek dit regtig gewaardeer dokter. Rêrig ... die tyd wat ek hier in die hospitaal is. Dis stil en rustig. Jy hoor niemand nie, jy sien maar net die karre verby, so dit was 'n regte tyd vir my om hiernatoe te kom.* (P4:55)

I appreciated being here a lot. It is quiet and peaceful. You do not hear anyone, you only see the cars passing; it was the right time for me to come to this place.

*...ek is baie beïndruk met die plek en wat ek van hou ... ek is vreeslik lief vir die natuur so ek gaan stap baie uit. Ek het vroeër... op die internet het ek gelees oor die geskiedenis van Weskoppies se hospitaal. Daar is historiese geboue en dit is goed wat my as ingenieur fassineer...* (P11:74)

I am very impressed with the place; I love nature and I walk a lot here. I read on the internet about Weskoppies Hospital. Being an engineer I am fascinated by the historical buildings.

Another patient described the walking between different activities on these large grounds as very therapeutic (P22:382).

### 4.3 ADMISSION TO DIFFERENT TEAMS

Patients are admitted to the different teams according to their diagnosis. This was something that drew positive comments.

*P (patient): So ek sê rêrig, ek is baie tevrede, die hospitaal is baie goed. Ek het dit nie verwag nie.*

*I (interviewer): Wat het jy verwag?*

*P: Ek het gedink, ek het gedink alle mense is in een saal. Alle mense wat baie meer probleme miskien as ek het dan sal daar wees. So ek het nie geweet dit was soos spesifieke mense of spesifieke departemente gehou nie. (P4:291)*

**Summary:** I am very satisfied, I did not expect this. I thought all types of patients would be in one ward, patients with much more severe problems than mine. I did not know that there would be specific departments.

*So dit is 'n baie goeie hospitaal, want hy het verskillende departemente waar jy gaan. Dit gaan volgens jou siekte, so hier raak dit lekker. (P4:271)*

It is a good hospital, because there are different departments; you are admitted according to your illness. This is nice.

This patient was relieved to not be admitted to a ward in which there were also severely disturbed patients.

### 4.4 OPEN WARDS

If possible, patients are admitted to open wards. Admission to an open ward means that the patient can move around freely, they can walk on the large grounds of the hospital, only needing to inform the nursing staff of their whereabouts. The different teams all have their own open wards with a different routine, ward rules and programmes, and patients are expected to participate in these therapeutic programmes and keep to the rules.

*Okay, daar is nog reëls, maar daar moet reëls wees, anderster gaan die plek uitmekaar uitval. (P2:35)*

OK, there are rules, but this has to be, otherwise the place will fall apart.

Exceptions to being directly admitted to an open ward are, for example:

- Patients at risk of serious harm to self or others
- Psychotic patients of such a degree that they cannot be managed in an open ward
- Very disruptive patients.

Patients who had to be admitted to a closed ward, but with treatment have been stabilised, are transferred as soon as possible to open wards. As can be expected, such transfers were experienced in a very positive way by the patients:

*Dis lekker. Dis beter. Dis meer menslik. Dit voel minder soos 'n tronk. (P2:19)*

This is nice, better. More humane. It feels less like a prison.

*Ek kan uitstap in die natuur. Ek kan onder die bome gaan sit en jy weet dit is baie rustig. (P2:123)*

I can walk in nature. I can sit under the trees and it is very tranquil.

*So in an open ward it's even much better, because the space is even more and then you are able to do whatever that you want to do in your own space. (P7:67)*

## 4.5 CLOSED WARDS

### 4.5.1 Introduction

A closed ward refers to a secure ward, where the patients are closely monitored and which they cannot leave. The closed wards are all built in the same way. At the entrance is a massive gate. In the front part is the sisters' station, offices for doctors doing rounds, rooms for visitors, a TV room and dining hall. Adjacent to this is a courtyard encircled by a

high wall. Another steel gate separates the front part of the wards from the back, where in every ward there are eight dormitories with four beds in each. Every dormitory has its own bathroom.

Closed wards elicit mostly very negative reactions. For some, it does not feel like a hospital where people receive care, but rather like a prison. The lack of structured, patient-centred activities also has a negative effect.

*...yesterday I just spoke with other guys and I think what I'm saying is something that they also said, it was like very bad for them as well. It's more like they are not in a hospital, but in a jail. The feeling is like we are locked up in a jail, not in a hospital. (P6:43)*

*It's tough, it is really tough. (P5:541)*

*...toe sale is mos half soos 'n straf. (P2:67)*

*...closed wards are like punishment.*

#### **4.5.2 Daily routine in the closed wards and being locked into the dormitories**

This patient described the daily routine as follows:

*Jy word toegesluit van 5 uur die aand tot 8 uur die oggend, dan is jy oop tot 12 uur, en dan eet jy dan is jy weer toegesluit van 1 uur tot 3 uur dan is jy weer oop van 3 tot 5 ... dan is jy in klein selle toegesluit. (P9:400)*

##### **Summary:**

17h00 – 08h00	Locked into dormitory
08h00 – 12h00	Allowed into the front part
12h00 – 13h00	Lunch
13h00 – 15h00	Locked into dormitory
15h00 – 17h00	Allowed into front part

Other patients have described a similar routine and complained strongly about being locked into the dormitories for 17 hours each day. While I was interviewing a patient, he drew my attention to the noise in the back of the ward. Patients were rattling the security door. He said that the noise would continue until they are let out of their dormitories at 15h00. He, and the patients at the back, were clearly very frustrated with being in a closed ward.

*Actually ... the only thing that we complain about is the locking, when we are locked up. Everybody feels it's too much and when we don't go out, and sometimes we think it's our time to be out, then it becomes a problem for us. We get irritated inside those rooms in our dormitories, so we end up even sometimes pulling the gates, trying to make noise just to let the staff know that we are, we've had enough. So that's the one thing that I believe that most guys are, we're experiencing the impatience. We don't have like patience to wait until the gates are opened, because there is no time that shows that we are around the time that we are supposed to be out, so it becomes a problem, yes. (P6:19)*

This patient describes how it feels being locked up and not knowing the time. (There are no clocks.) The staff could make use of the time, he said, but because the patients did not know the time, they could not use it. He found that this added to their distress:

*I: But could this feeling also have to do with you feeling that the time here in the ward is not really structured, that it feels very empty and too long or boring?*

*P: Yes, and what you say is precisely what I think, because the time is more like it's... they are using the time, but we're not... we can't be using the time they are using as well, because if they're doing whatever they are doing as the nurses and the staff this side, we don't really know what exactly is the time. If ever we had time, we would always keep on checking, oh they're doing this, we will understand, because of the time is this now. (P5:81)*

A patient stated that the only activity organised for them in six weeks was one group activity (P14:346). Another patient said that in two months she was never allowed or taken out of the closed ward (P16:89).

*I think you feel bored. I think you feel a lot more boredom. Besides boredom you feel cornered. Like imprisoned. (P12:80)*

*...we spend most of our time here doing nothing. (P5:197)*

*...omdat die mense so verveeld is hier binne en hulle voel hulle kan niks doen nie en dan bou ... frustrasies bou op en dan het dit net tot breekpunt gekom. (P1:55)*

*...because people are bored in here and feel they can't do anything, frustrations build up and then it just reached breaking point.*

The long hours locked up is also seen as punishment (P18:20). Can being locked up for too long exacerbate mental illness?

*Because the more we feel locked up ...the more we act strange and then we end up doing things that are somehow not okay; not alright according to our doctors. (P6:303)*

It can certainly with certain patients lead to more acting out and to more behavioural problems. It can also have other negative consequences, as expressed by this elderly female patient as well as other patients:

*Nee, dit breek 'n mens af dokter. Dit is rêrig soos 'n tronk. Dit breek my heeltemal af. (P9:396)*

*It wears you down. It really is like a prison. It totally destroys me.*

*It's a bit stressful if you stay here for a very long time. You end up getting stressed, especially because I've stayed in a closed ward for also a long*

*time. So I got stressed and I think it started affecting me with my illness as well, because I started getting very paranoid ... (P17:56)*

*... want dit is vir my 'n baie lang tyd om in so 'n plek te bly, veral in 'n toe saal, want as jy, want enige mens wat by sy normale verstand is, sal van sy kop afraak ... (P2:119)*

*....it is a long time to be in such a place; any normal person would go out of his mind, go crazy...*

Patients highlighted how different the experience can be according to the mental state of the patient. The fourth patient (P6:323) described how difficult it is for a patient who is not very ill, e.g. psychotic, to be in a closed ward. This was echoed by the tenth patient who said:

*I'll say I've discovered it's not difficult. If you are sick it is not difficult, but if you are not sick, it's difficult then. (P16:47)*

#### **4.5.3 Feeling helpless**

Being in a closed ward can contribute to feeling helpless and irritated, having to wait a whole week for the next consultation with the registrar, to then try and convince the doctor that one can be transferred to an open ward. (The registrars' routine will be discussed in Chapter 6; a short description of their weekly program was also given in Chapter 3.)

*That's the most irritating feeling because I don't know how long I'm gonna be kept here and what exactly must I do, because my doctor said, if I behave well, if I take my medication, then the possibility of an open ward ... (P6:327)*

All of this is aggravated by at times not knowing whether the doctor will see you that week!!

*I: Dr X is in the ward now, has she seen you today?*

*P: No, not yet.*

*I: When will she see you again?*

*P: I don't know, because she said she was going to see me again next week. But I don't know whether today she is going to see me or not. Because I'm really not sure of that. (P6:292)*

*It's helpless ... (P6:43)*

The problem could be alleviated if other team members see a patient as well. This, however, is not always the case in a closed ward. This patient, after having been in a closed ward for several weeks, didn't even know there was a MDT:

*I: Has any other member of the team seen you?*

*P: The team?*

*I: Yes. Do you know of the team?*

*P: No, I don't know the team. (P5:359)*

If a patient in a closed ward becomes unmanageable, he or she can be put into seclusion for a limited period; this will be according to strict rules drawn up by the management of the hospital and according to national policies and international guidelines. Staff members (doctors, nursing staff and others) who work in a psychiatric hospital for a long time can, however, become emotionally blunted and forget how traumatic certain experiences are for patients:

*Toesluit, daar is niks erger as dit nie. (P19:256)*

*Being locked up - there is nothing worse.*

*Ek dink dat die vrees is baie want die toesluit is so skrikwekkend. Die trauma wanneer jy besef hulle vat nou jou oorbelletjies, en hulle vat jou horlosie en hulle vat jou selfoon en hulle vat jou mooi klere en hier gaan jy nou. (P20:140)*

The anxiety is intense because being locked up is terrible. The trauma when you realise that they are now going to take your earrings, your watch, your mobile phone and your nice clothes and here you go.

#### 4.5.4 **Forced treatment**

*Dit gaan nie help ek baklei, want hoe meer ek baklei hoe meer, hoe meer stresvol is dit. So nou los ek dit maar dat hulle maar inspuit. Hulle weet waar ek staan, hulle weet ek hou nie van die inspuiting nie. Hulle weet ek wil dit nie rêrig hê nie, maar nou los ek dit maar, want dit help nie, dit help nie om te baklei nie. (P1:87)*

It does not help to fight, because the more I fight the more stressful it is. So I accept the injection. They know I do not like the injection. They know I do not really want it, but I stopped fighting because it does not help to fight.

*En dit was, dit was soos regtig soos 'n straf gewees en in al daai tyd het ek geweier om medikasie te gebruik. En toe het hulle gesê, die dokter het vir my gesê, as jy nie jou pille drink nie gaan jy nie pas kry nie. Toe na omtrent twee maande, toe begin ek die pille drink net sodat ek kan pas kry om my familie te sien, om 'n bietjie uit te gaan. Toe het ek nou ingegees. Eintlik wou ek nie ingegees het nie. Dit is soos 'n stryd wat jy voer. (P2:95)*

**Summary:** The patient refused to take medication; the doctor then said that he will only get a pass if he does take the medication. After two months the patient gave in and took the medication, just to be able to get a pass to see his family. He did not want to give in. It is like a battle that you fight.

It is an indication of how difficult it was to accept medication that this married man with two small children refused it for two months! Was this the only way of handling this?

#### 4.5.5 The transfer to an open ward

To be transferred from a closed to an open ward is a relief and seen as an opportunity to prove yourself to the doctors, to show them that you are now better and that you deserve to be in an open ward. It is interesting that establishing a friendship, a type of relationship, would prove to this patient that he is mentally healthier:

*...but I would just see whether I can establish a friendship with the other patients in that open ward. If I could be able to establish that, then it means then my problem would be solved ... (P7:67)*

To help others would be further proof of being better:

*...to be on an open ward and prove to the doctor that I can be of help to others as well. (P7:71)*

The last two quotes emphasise the importance of relationships, the central theme of this thesis. The following quote is about the relief of being transferred to an open ward:

*Wel, die betekenisvolste was wanneer ek in 'n oop saal kom. Byvoorbeeld by (saal) 37 was daar 'n klavier en ek kon klavier speel en ek kon sing en ek kon musiek maak. (P19:40)*

The most meaningful experience was when I was transferred (*from a closed ward*) to an open ward. For example in ward 37 there is a piano and I could play and sing and make music.

And yet, sadly, for some even a closed ward is a home:

*No, it's okay to be here, because I've got nowhere to go anyway. (P15:183)*

## 4.6 SEXUAL NEEDS LINKED TO LONELINESS

Patients at times have sexual relations with each other. They are obviously discouraged from doing this, but it is something that cannot always be controlled. This patient started talking in the interview about sexual needs and possible abuse in the hospital:

*I: Are you worried that you might be open to sexual abuse?*

*P: I think so.*

*I: What would make you then vulnerable to such a thing?*

*P: My relationship at present, because I've spent too long in the hospital, my relationship with my current partner is not well, and I feel I can just freely ... let me just get any partner from the hospital, at least we share something in common, we've got the same mental illness.*

*I: Do you feel lonely here in hospital?*

*P: Yes.*

*I: Very lonely?*

*P: Too lonely. (P18:126)*

## 4.7 ETHICAL VIOLATIONS

Unfortunately, some patients described situations that are totally unacceptable. A female patient had the following to say about a closed ward:

*P: Oh ... dit was hel. Die susters slaan die pasiënte. Hulle vat hulle isolation toe en dan trek hulle hul klere uit en dan los hulle hulle daar binne. Ek gaan eerlik wees, die pasiënte slaan die verpleegsters ook. In die oggende staan jy kaalgat in 'n tou en jy moet gaan stort. Jy staan soos 'n ry beeste.*

*I: Almal?*

*P: Almal nakend. Jy staan in 'n ry en dan was jy en soos wat jy uitklim kry jy 'n handdoek en jy moet aantrek. En dan is daar 'n tandeborsel houër, jy vat 'n tandeborsel en jy borsel jou tande jy gebruik nie eers jou eie tandeborsel nie. En hulle jaag jou aan heeltyd, die hele tyd. En in die aande moet jy jou nagklere ook voor almal aantrek. Die suster sit daar, jy trek uit voor hulle en*

*jy trek aan voor hulle. So daar is geen privaatheid nie. En jy word toegesluit en dan kom jy, jy word toegesluit van net na ete tot so teen na half drie se kant en dan kry jy koeldrank of koffie en daar is net son, so jy sit heeldag in die son. En dan vanmiddag kry jy jou aandete en dan sluit hulle jou toe tot agt uur wat jy jou pille kry, tot more oggend toe en hulle is altyd laat met jou pille. (P13:524)*

P: It is hell. The sisters hit the patients and put them into isolation after the patients had to undress. To be honest, the patients also hit the staff. In the mornings you stand naked in a row to shower. You stand in a row like cows.

I: All (patients)?

P: All naked. You stand in a row and wash yourself, as you climb out you get a towel and you have to dress. And then there is a container full of tooth brushes, you take one and brush your teeth and you don't even use your own tooth brush. And the whole time they urge you to do it quicker. And in the evenings you have to put on your pyjamas in front of them. There is no privacy. You are locked up from just after lunch till half past two, then you get a cool drink or coffee and sit in the sun. Then you get your evening meal and then you are locked up till eight when you get your medication and then till in the morning, and they are always late with the medication.

Another patient made the following allegation:

*P: But the problem is the people that run the hospital. I don't think they deserve to run the hospital because I was beaten up in that... in the cell.*

*I: You were beaten up?...with this admission?*

*P: No, not now.*

*I: The previous admission?*

*P: Yes. (P15:51)*

Similar comments were also made by other patients (P19:270). And even worse:

*P: Dit was hel somtyds as hulle jou toesluit in daai klein kamertjie, dit is hel ... Toesluit, daar is niks erger as dit nie.*

*I: Kan jy my 'n bietjie daarvan vertel?*

*P: Dit is iets wat, dit maak selfs seer om net daaraan te dink. Ek het gewoonlik gesing, godsdienstige koortjies en liedjies gesing en gesange wanneer ek toegesluit word, aaneen en aaneen en aaneen gesing.*

*I: Hoe lank was jy op eenslag toegesluit?*

*P: Ek kan nie onthou nie, maar somtyds was dit oornag, of twee of drie dae, ek weet dan kon ek nie toilet toe gaan nie, dan moes ek myself help op die vloer. (P19:252)*

**Summary:** To be put in seclusion is hell, nothing is worse. The patient said that she would continuously sing religious songs whilst being locked up overnight, or for two or three days, although she initially said that she could not remember exactly the duration of being locked up. There were also no toilet facilities and she had to relieve herself on the floor.

These were very disturbing comments. I discuss in Chapter 11 how I handled these ethical dilemmas.

#### 4.8 OTHER COMMENTS

About the length of stay without any pass:

*...ons gesels maar, jy weet, en praat mekaar maar moed in en so, want dit is nie lekker om vir drie maande, twee en 'n half maande in 'n hospitaal opgeneem word wat jy nie een keer kan pas kry nie. Dit is baie 'demoralising', dit is glad nie lekker nie. En dit maak 'n mens nogal negatief. (P8:55)*

*...we talk and try to support and encourage each other, because it is not nice to be admitted for three, for two and a half months, and to not once get a pass. It is demoralising, it is not nice at all. And it leads to negativity.*

The food was in general found to be acceptable, although there were complaints about too much starch and a lack of vegetables or fruit at times. But, according to some the food was not good at all (P12:207 and 208; P14:389).

*Huidiglik is ons kos situasie baie swak. Ons kry geen vrugte en nie groente nie. (P12:208)*

*At present our food situation is very bad. We do not get fruit or vegetables.*

There were also some comments about cleaning and cleanliness of hospital; this differed amongst wards. Some comments were negative, one patient described it as 'surface cleaning' (P22:166); another described the bathrooms as 'smelly' (P14:829), yet there was also a very positive comment about the work done by the cleaners.

#### **4.9 SUMMARY OF CHAPTER 4**

In this chapter, I gave an overview of the initial experiences in the hospital, described the admission process and sketched the situation in the different types of wards. I described some of the experiences patients had in open and closed wards, as well as the routine in the closed wards and how this affected the patients. Being in a closed ward is nearly always a terrible experience for a patient and I narrated how helpless a patient can feel. The transfer to an open ward is then a huge relief. I also gave a short description of the intense loneliness patients can experience.

Patients unfortunately also described severe, unacceptable violations of privacy and human rights. I shall address this, as well as my response to it, in Chapter 11.

## 5 HOLDING AND CONTAINMENT - OR THE LACK THEREOF: THE PRIMARY FACTORS

I discussed with my supervisor how to represent the data about the different team members. We considered ordering it into themes, e.g. 'respect', or 'being listened to'. What the patient had to say about the various team members would then be integrated into these topics. However, my aim is to try to understand how the patients interact with the different team members, cleaners and other patients. We decided rather to discuss each discipline on their own, even if this might lead to a duplication of topics, since in our view this gives a better overview and understanding of the interaction between the different team members and the patients.

In this chapter, I therefore describe the different levels of containment as expressed in the interaction of the patients with the different staff members.

The 'primary factors' described in this chapter are

1. Nursing staff
2. Registrars
3. The rest of the MDT (psychologists, occupational therapists, social workers)
4. Fellow patients, cleaners and medical students

Management is mentioned as one of the containing circles. Since patients do not directly interact with management this topic was not addressed in the interviews. Management, therefore, does not form part of the description in this chapter, but their role will be discussed in Chapter 9.

The nursing staff form the first level, closest to the patient; the rest of the MDT with the different members, e.g. the occupational therapists, are 'lower down'. This organisation does not, however, reflect the importance of the levels; this will vary with different patients. For some a registrar and for others the OT or a fellow patient might become the most important person.

## 5.1 NURSING STAFF

Nursing staff form the backbone of any hospital. They are there all the time, in constant contact with the patients, taking care of them. Their primary function can be described as a motherly one, providing nurturing and containment. They determine the attitude and milieu in the ward, something the patient registers the moment he or she arrives for admission. This can have a big influence on the experience and outcome of care.

Because of this key role, they are described here as the first level of containment.

### 5.1.1 Positive experiences with nursing staff

#### 5.1.1.1 Introduction

For a patient a certain tone is already set on arrival, hopefully a welcoming one, as mentioned in this quote:

*P: ... I was in ward X last year as well, this year again; getting to the ward was welcoming.*

*I: Welcoming.*

*P: Yes, it was welcoming. It was nice. The ward orientation was done well, thoroughly, so that was nice. You then start to feel at home. (P22:25)*

#### 5.1.1.2 Attitudes and attributes

Attitudes and attributes of staff, important in patient care, are shown in various ways, such as:

##### **Respect and understanding**

To respect a person is of great importance. It is something we owe others, but it also builds alliances.

*I: Kan jy sê dat Sr R en Sr P enige spesifieke kwaliteite het wat dit vir jou makliker maak?*

*P: Ek dink hulle het respek vir jou en hulle weet dat jy deur 'n moeilike tyd gaan. (P13:110)*

**Summary:** These two sisters show respect to patients, they understand the difficulties patients go through, and this makes it easier.

But respect for the sister-in-charge is also important for the ward-milieu:

*En ook mans waarmee sy te doen gehad het, het haar so gerespekteer, al was daar konflik ... sy kon onmiddellik die situasie hanteer. (P21:40)*

And the men respect her as well; she could handle it immediately if there was conflict.

### **Interest in the person**

For any patient it is important to know that staff members are interested in him or her as a person.

*Dit sal net vir my lekker wees as ek weet daar is mense ... as dit darem net lyk of iemand belangstel in my, dan sal dit baie help om my positief te hou. (P8:35)*

It would be nice if I knew that there are people ... if it just looks as if someone is interested in me; that will help a lot to keep me positive.

*P: So dit is 'n sinvolle verhouding, en ja, met die staflede het ons ook, staf M veral. Ek het ook 'n sinvolle verhouding met hom opgebou.*

*I: Jy noem hom nou talle kere. So dit klink regtig asof hy tog vir jou 'n besondere persoon was.*

*P: Ja, hy was. Hy is.*

*I: Nou hoekom? Hoekom juis hy?*

*P: Want hy is 'n persoon wat baie omgee vir mense. Hy sal met jou kom mooipraat en hy sal sy hand op jou skouer sit en jou vriendelik groet en jy*

*weet hy is 'n mense mens. Jy weet hy weet hoe om met mense te werk.*  
(P2:139)

**Summary:** For this patient the staff member M had really become important; he is described as a person who cares about others. He will talk to you in a friendly way and will put his hand on your shoulder. He knows how to interact with others.

This patient highlights the central theme of my thesis: here is a nursing staff member who is valued because he is focussed on the interaction with other persons, with patients. Small gestures from this staff member are appreciated, but this is only part of his general positive attitude to patients.

### Listening

Listening to someone is such a basic activity, but for many so difficult. It can, however, mean so much to a patient.

*...gisteraand het ek met 'n verpleegster gesels, en sy het geluister, en ek kon slaap want sy het geluister.* (P19:168)

...last night I talked to a nurse and she listened, and I could go to sleep, because she had listened.

*I: Is daar enige ander kwaliteite wat sy (Suster J) as mens het wat jy besonders vind?*

*P: Sy is altyd opgeruimd, altyd positief. Sy het altyd 'n goeie woord vir jou te sê. Sy sal die negatiewiteit uit jou uitpraat en vir jou sê, nee, more is 'n nuwe dag en sy sal met 'n probleem, as jy 'n probleem het, sal dit aanspreek. Sy nooi jou uit om met haar te kom praat, die ander nooi jou ook uit, maar sy luister werklik.* (P9:218)

**Summary:** Sister J is described as cheerful and positive; someone who will have a good word for you and will address your problems. She will invite patients to come and talk to her and she really listens.

Patients value being able to talk to someone who is prepared to listen.

## Talking

Talking means sharing, also sharing that which is difficult to bear alone.

*P: Wat my baie gehelp het, ek het die susters gehad en die maatskaplike werkster en die sielkundige werker, want jy kan jou probleme vir hulle sê, dan voel jy beter, dokter.*

*I: Goed om met hulle te praat.*

*P: Om met hulle te praat ... (P4:43)*

**Summary:** What helped a lot was being able to talk to the sisters, the social worker and the psychologist. You can share your problems with them, then you feel better.

*I: Nou as dinge opkrop wat sou dan gebeur? Jy sê jy sal ingee, maar wat sou gebeur as jy ingee?*

*P: Ek weet nie dokter. Ek sal goed begin rond gooi. Ek sal begin skree, ek sal seker daai nuwe meisie wil aanrand.*

*I: Ja. So om te praat help jou om daai gevoelens dan op 'n manier te verwerk.*

*P: Te beheer. (P10:61)*

**Summary:** Talking helps to control difficult feelings; if she could not talk to staff members it might lead to serious acting out.

*I: Is daar enige iets in hierdie tyd in die sewe weke (in WKH) wat vir jou uitstaan? Wat vir jou rêrig 'n belangrike ervaring of belewenis was?*

*P: Die feit dat ek met Sr R kan gepraat het oor enigiets. Sy het my altyd bygestaan veral as ek neerslagtig raak of ek gelê en huil het. Sy was altyd daar gewees vir my en ek was gemaklik met haar gewees. Daar is baie dae wat ek huil wat sy na my kom soek en dan met my praat. (P13:58)*

I: Is there anything in these seven weeks (in WKH) that really stood out? That really was an important experience for you?

P: The fact that I could talk to Sister R about anything. She was always supportive, especially when I was feeling depressed or crying. She was always there for me and I felt comfortable with her. There were many days when I cried and she would come and look for me and talk to me.

For this patient this was the most important experience in hospital!

### **Fighting for and pleading with a patient**

Fighting for a patient sends a message that his or her well-being is important to the staff. It can help to motivate a patient.

*P: ... die staf het my mooi gevra, hulle het hard vir my baklei om my oop saal toe te stuur. Hulle het my mooi gevra, moet asseblief nie wegloop nie. Moet ons nie in die steek laat nie, want hulle het vir my baklei by die span om my, om my oop saal toe te kry. En ek waardeer dit; toe het ek vir hulle gesê, nee, ek sal goeie gedrag, jy weet, openbaar en ek sal nie, sal julle nie in die steek laat nie. (P2:115)*

**Summary:** The staff pleaded with the patient and said that they had done their utmost to get him transferred to an open ward. They pleaded and asked the patient to not disappoint them. He appreciated their concern and said that he will cooperate in the open ward and not let them down.

#### **5.1.1.3 The importance of nursing staff**

Nursing sisters become very important to patients, even the most important persons. A patient described some of the interaction with a sister in the following two quotes:

*Sy sal partykeer kom en my net 'n drukkie gee en my vra hoe gaan dit en dit is asof sy kan aanvoel ek voel nie lekker nie. Of sy sal vir my sommer net*

*kom op my rug tik en my vra hoe gaan dit. Dit is asof sy meer menslik is teenoor my. (P9:208)*

She would at times just give me a hug and ask me how I am, as if she can sense that I'm not well. Or pat me on the back and ask how I am doing. It is as if she is more compassionate and kind-hearted towards me.

To just pat a patient on her back seems like such a small thing, but this patient held on to this memory. The same patient distinguished between feeling like a human being and like a patient. Why this difference?

*Sy laat my voel soos 'n mens en nie soos 'n pasiënt nie. ... dit is opbouend vir my, dokter. (P9:216)*

She makes me feel like a human being and not like a patient ... this is uplifting to me, doctor.

This patient highlighted the availability of the nursing staff as very important. She would rather speak to a nursing sister today or tonight, than to have to wait for the registrar. This is especially understandable if one has to wait for a whole week for the registrar to see you again.

*Dokter, dit is nou vir my makliker as ek by Sr J kan uitkom as by Dr G. Dr G sien ek een keer 'n week. Sr J sy werk nagskof en ek kan haar elke aand sien. Enige tyd wat ek 'n probleem het, kan ek na Sr J toe gaan. Met Dr G kan ek ook met 'n probleem gaan, maar ek moet 'n week wag. Sr J is makliker bereikbaar. Makliker beskikbaar vir my. (P9:252)*

**Summary:** It is easier to reach Sister J than Dr G, because Sister J works every night. The patient can talk to her at any time. She could also talk to Dr G, but would have to wait a whole week.

*I: Het ek jou daar reg verstaan, dat die interaksie met haar vir jou die mees belangrike eintlik was?*

*P: Ja, want sy is altyd daar vir jou. Jy kan altyd met haar gaan praat oor enigiets. Sy sal nie vir jou sê soos die ander susters, “wait I’m busy” nie.*  
(P13:98)

**Summary:** The interaction with a sister was the most important, because she was always there for her. You could talk about anything to her. She would never say like the other sisters “wait I’m busy”.

For some patients nursing staff are like a mother figure:

*En sy is soveel jonger as ek, maar dit is vir my of sy rêrig vir my ’n moederlike figuur in hierdie plek is.* (P10:47)

She is much younger than I am, but she is really a mother figure to me in this place.

#### **5.1.1.4 But things can go wrong**

Sometimes the milieu in the ward is not determined or controlled by the nursing staff. This can for example happen if the percentage of patients with severe personality disorders is high, if primitive defence mechanisms such as denial, projection, splitting and acting out kick in and the staff do not manage to provide containment. Such wards ask for a head nurse who can regain control by setting limits and boundaries in an emphatic but caring way, a difficult task. Such a sister is described by this patient:

*En ook mans waarmee sy te doen gehad het, het haar so gerespekteer, al was daar konflik, kon sy dit onmiddellik, dit was soos ’n ‘relay’, sy kon onmiddellik die situasie hanteer.* (P21:40)

And the men also respected her; if there was conflict she immediately could handle the situation.

A difficult ward situation demands a lot from the nursing staff to try and contain the situation.

### 5.1.1.5 Burnout? The positive experience with trainee staff

Burnout is a threat to staff who work in a difficult environment, such as a closed ward, for many years. This can lead to a loss of a therapeutic stance and problems in the staff-patient relationship. Such factors could have played a role in this patient's experience of trainee nursing students, still full of energy and a desire to help. The patient became really animated when describing this; it was clear that these experiences had meant a lot to him.

*I: What experience did really stand out for you? Was there any experience that really was special or helpful?*

*P: Special, yes, there was an instance where there used to be staff that was trainees, they were trainees, the nurses, female and male nurses, they were coming in. (P5:147)*

He said that he had felt treated as an equal. We continued:

*I: I just found it interesting that you said these trainee nurses that came in treated you as equals, as not someone who is sick, but just as a fellow human being.*

*P: Yes.*

*I: ... do you think it might have to do with them being trainees that they were... that they had this different positive attitude?*

*P: Possibly, because as trainees they were more like people who were not exposed so much to this kind of environment. ... whatever that the staff told them, make them to be able to blend with us and not look at us as patients, but look at us as fellow human beings, because they were able to learn from us as well and we were able to learn from them. And they were able to take the knowledge that they got from us and utilise it to better their careers, I think.*

*I: It sounds as if they approached you in a very open way, not with preconceived or preformed ideas.*

*P: Exactly.*

*I: And that was very meaningful and helpful.*

*P: In a big way... in a big way. It really meant a lot to me because they were not judging us, yeah..... they were there asking us questions like normal people, not like people who are mentally ill or something like that, but normal people. ... They respected us. ... (P5:165)*

*I even taught one male nurse basketball. There was a basketball here, so I'm a very big fan of basketball and I play basketball a lot. So I even taught that one guy how to score and he managed to be able to learn from me and he said to me, he's going to try and practice as he goes home; whenever he gets a ball he's going to keep on practicing. So for me it was an eye opener that somebody can take something like that from me, it was good to... it was more like a highlight as well. (P5:151)*

Several important issues are highlighted in his comments:

- Junior staff of all disciplines can play an important role in the care and treatment of patients.
- Patients are first our equals as human beings and only then patients.
- Those who treat can learn from patients; a valuable experience for patients.
- Being exposed for long 'to this kind of environment' can affect staff, it can cause weariness, emotional blunting and ultimately burnout.

## **5.1.2 Negative experiences with nursing staff**

### **5.1.2.1 Experiences with nursing staff in closed wards**

As already mentioned, the situation in the closed wards can at times be difficult and some patients complained about receiving bad treatment from the nursing staff. I already quoted the patients (Chapter 4.7) who said that patients and staff would hit each other and that patients were put into seclusion for long periods of time. Other comments were:

*... daar is altyd 'n bakleiery, dis 'n moeilike saal in om te lewe. Die susters het geen respek vir die pasiënte nie, die pasiënte het geen respek vir die susters nie. (P13:552)*

*...there are always fights, it is a difficult ward to be in. The sisters don't have any respect for the patients, the patients don't have any respect for the sisters.*

*I: Do you have any comments about the training of the people here? The training of the doctors? Do you think there is something that really needs - in the training - to be addressed?*

*P: The sisters can be very mean to patients sometimes ... If a patient doesn't want to take medication they will beat you, they will do everything, they will kick you. They will tear your clothes, just to give you the medication. (P18:638)*

According to this patient no ward rounds were done at night in the closed ward:

*I: ... so just to say that again. Has there never been any rounds done by the nurses between 8 o'clock and 5 o'clock?*

*P: Not in that wards there. Here I find some doing it. Not in that ward. This one they do it better. In that ward on no occasion did I see a nurse, because that side you see them ... oh, they came one night because little things make me awake. (P14:326)*

These patients describe unacceptable situations and happenings. Some of these have already been addressed by management, e.g. seclusion rooms nowadays all have their own toilets, but other problems still persist. To only point fingers at nursing staff would miss the point; the problem is much more complex - I address this in Chapters 9 and 11.

### 5.1.2.2 Everything that you say is written down (observations)

The nursing staff are trained to observe and monitor the patients and to keep record of everything that happens in the ward. The way this was done was upsetting to this patient and experienced in a negative way:

*P: ... vir my gaan dit oor alles wat jy sê en doen word neergeskryf.*

*I: En wat beteken dit? ... Is dit wat neergeskryf word amper asof dit teen jou tel?*

*P: Teen jou tel ja, want as jy huil skryf hulle dit op. As jy nie wil eet nie, skryf hulle dit op. As jy heeldag slaap skryf hulle dit op. As jy emosioneel is of jy skop 'n tafel skryf hulle dit op. As jy met 'n pasiënt baklei skryf hulle dit op. (P13:424)*

**Summary:** Everything is written down, as if it counts against you. If you cry, or do not want to eat, or want to sleep the whole day, if you are emotional, or kick a table, or fight with a patient; everything is written down.

This is an example of something small that evoked negative feelings in a patient. Could it be handled differently? But, maybe it is not such a small thing; it could be linked to what Mullen (2009) writes about an observation culture that has developed in nursing to the detriment of relating to and interacting with the patient.<sup>11</sup>

### 5.1.2.3 Conflict in the ward between staff and patients

*P: ... hulle het begin skree opmekaar.*

*I: Die personeel?*

*P: En die pasiënte. En dit was net na Godsdienste, elke keer as hier iets gebeur is dit net na Godsdienste. Dan vra hulle nou of iemand nou 'n klagte het en dan loop dit altyd uit op 'n bakleiery. (P10:87)*

*P: ...they started to shout at each other.*

---

<sup>11</sup> See Section 8.2.5.

I: The staff?

P: And the patients. And it was immediately after morning devotion; every time when something happens it is immediately after morning devotion. The staff asked whether there were any complaints and then it developed into a fight.

#### 5.1.2.4 A reactionary attitude with lack of containment

A problem with regards to containment is described by this patient:

*Ja, hulle gee om, maar ek kan eintlik niemand sleg praat nie. ... Jy moet hulle net nie verkeerd opvryf en hulle kwaad maak nie. Maar as jy vriendelik is met hulle, dan is hulle vriendelik met jou en hulle gee om en hulle weet die pasiënte is siek en hulle sal uit hulle pad uit gaan om jou te help ook, mits jy vriendelik is teenoor hulle. (P1:138)*

Yes, they care, I can't talk badly about anyone. ...you should just not handle them in a wrong way and anger them. But if you are friendly, then they are friendly with you and they care and they know the patients are ill and they will go out of their way to help you, as long as you are friendly towards them.

The patient describes the staff as reactionary; that is, their actions depend on your actions. Containment, however, implies an ability to not react, but to keep providing a safe space in spite of the actions of the patient. This includes setting limits.

## 5.2 REGISTRARS

There are 20 approved registrar posts at WKH for medical doctors who want to be trained as psychiatrists. (At the time of the study 18 posts were filled, two are at present not available due to financial constraints.) All registrars rotate through the various training stations on a four-monthly basis; these stations include five adult teams, forensic psychiatry, child and adolescent psychiatry, clinics, two peripheral hospitals and neurology. This means that if all 18 posts are filled, 14 to 16 registrars will work at any given time in WKH.

The registrars are discussed as the second circle of containment since, apart from nursing staff, doctors are the central figures in a hospital setup. As for nursing staff, the study participants recounted positive as well as negative experiences with registrars.

## 5.2.1 Positive experiences with registrars

### 5.2.1.1 Registrars are important

Registrars can become very important to their patients. An elderly patient expressed an intense wish to follow up with a certain registrar, to be able to continue the discussions they had started during admission:

*Ek sou bitter graag met Dr M (wil opvolg), ek wil, ek het nog nie die nuwe dokter ontmoet nie. Ek vermoed dit is dalk Dr Y, maar ek sou bitter graag as 'n buitepasiënt net met hom (Dr M) 'n bietjie wou... Nie soseer medikasie nie, net met hom gedagtes te wissel. (P11:334)*

I would desperately like to follow up with Dr M; I don't want to meet the new doctor right now. I suspect it will be Dr Y, but I would dearly love to be able to ...not really about medication, but to be able to discuss things with him (Dr M).

Patients are also observing the doctors in the wards; they discuss them and form opinions about them.

*I: Are you saying that Dr B is more in the ward than the other doctors?*

*P: Yes, sir.*

*I: So you admired that.*

*P: Yes, sir. (P14:1049)*

They also note how a doctor approaches his work, whether his or her heart is in it or not.

*Nee, dit was vir my absoluut 'n baie goeie ondervinding, want ek was baie gelukkig om Dr M as 'n psigiater te kry en daai man het 'n ongelooflike passie vir sy pasiënte. Hy het ure, letterlik ure en ure met my gespandeer.* (P11:70)

It was a very good experience for me, because I was lucky to have Dr M as psychiatrist; he has an unbelievable passion to his patients. He spent hours with me.

### 5.2.1.2 Belief in the doctor

*I don't know, I would hear with the doctors, the doctors that they prescribe medication. Me, I can't say I want this and I want this. I just only say, to say the treatment that is right to me, but the doctors, they will prescribe the medication to say, you must take to this medication also. Yes. I would hear with the doctor.* (P3:315)

To accept the doctor as authority whose instructions one has to follow is considered old-fashioned nowadays, yet some patients still operate within a paternalistic model. The beliefs of these patients have to be respected.

### 5.2.1.3 Attributes of doctors who become important to their patients

#### Listening, the basis of a therapeutic relationship

Being responsible for the psychotherapy training of the registrars, I am very aware of the anxieties and difficulties nearly all registrars experience when they start seeing patients for psychotherapy. They lose their natural ability to be with someone and become rigid and stilted. Just listening to a patient feels as if it is not enough; it is as if something needs to be *done*. Yet patients appreciate 'just to be listened to'.

*I: Wat sou jy dus sê tydens jou behandeling was vir jou rêrig hier van waarde? Wat was werklik 'meaningful, helpful'?*

*P: Die feit dat hulle bereid is om te luister na jou.* (P11:92)

It was really helpful and meaningful that they were prepared to listen to me.

*Ek moet sê Dr L is 'n baie goeie dokter. Hy het rêrig ... hy luister baie mooi na wat 'n mens sê. (P21: 196)*

Dr L is a very good doctor. He really...he listens carefully to what you are saying.

Good patient care involves attending to the therapeutic relationship and listening to the patient. It is much more than making a diagnosis and prescribing medication, as illustrated by the following quote:

*P: Hulle (die kliniese assistente) moet dalk net meer, ek sal sê persoonlik met die ... meer 'n persoonlike verhouding met die pasiënt behou, as net te kom sit en sê wat is fout met jou, hoekom voel jy so. Okay, kom ons sit vir jou hierdie pilletjie op, of ons haal hierdie pilletjie af.*

*I: So dit sou tog belangrik vir jou wees as daar so 'n persoonlike verhouding sou kon opbou?*

*P: Soos wat ek en Dr W gehad het.*

*I: Ja, waar julle vir mekaar leer ken.*

*P: Ja.*

*I: Sluit dit dan meer in as net die medikasie?*

*P: Ja, daar was 'n persoonlike verhouding.*

*I: Wat is die verskil?*

*P: Hy het na jou geluister. (P13:652)*

**Summary:** The registrars should build a personal relationship with the patient and not only attend to symptoms. According to this patient, she had such a relationship with Dr W, *because he listened to her.*

## Acceptance

Acceptance of one's beliefs:

*I: And he was interested in your religious beliefs and didn't just condemn those?*

*P: Yes, sir.*

*D: Ok. So that's why you would want to see him?*

*P: Yes, sir. (P14:1059)*

And acceptance of a lower functioning patient:

*I: But did Dr Y or Dr Z help you in any other way?*

*P: Yes.*

*I: How? What did they do?*

*P: It's not harassing, it's talking nice and smiling nice and not harassing and then if you not understand ... to help me ...not closing their heart, it is open in their heart ...if you not understand, they talking all right. (P16:337)*

## Feeling more than just a number

Many patients expressed the wish to be more than just a number; this is just one example:

*I: Jy het gesê dat met Dr M het jy gevoel jy is nie net nog 'n nommer nie.*

*P: Absoluut. Hoe hy dit regkry weet ek nie. (P11:236)*

**Summary:** With Dr M the patient did not feel like a number; he does not know how Dr M achieved this.

## Approachable, easy to reach

A patient smiled on recalling this memory:

*P: No, it's very strange, because you know what, with Dr B my parents used to call him on the cell phone and he would answer them and talk to them. He's the only doctor that I feel has been there for patients.*

*I: So he is really approachable.*

*P: Ja. (P18:624)*

*Dr B is ook 'n goeie ou, 'n vriendelike ou. En 'n mens kan hom benader ... hy het 'n oop deur policy. Hy is nie kortaf met jou of so nie. So ek glo ek en hy sal 'n betekenisvolle pad kan stap. (P2:1)*

*Dr B is a good and friendly person. He is approachable ...he has an open door policy. He is not abrupt with you. I therefore believe we can walk down a meaningful path together.*

### **Not giving up**

*I: Wat dink jy is dus ... die belewenis met Dr X wat die meeste gehelp het?*

*P: Dokter ek dink die feit dat sy, al is ek partykeer nie in die 'mood' om te praat nie, dan sal sy nog probeer. Sy probeer dat ek praat of dat ek iets sê en dan, ek vir haar sê ek weet nie, dan sal sy dit aanvaar en sal nie aandring op 'n ding wat ek nie oor wil praat nie. (P5:544)*

**Summary:** The experience that helped her the most with Dr X was that she (*the registrar*) did not give up; even when the patient was not in the mood to talk, she would still try to get the patient to talk, although she would also accept it if the patient really did not want to discuss something.

This is a small example of something of great importance in psychotherapy: to convey a message to the patient, verbal and non-verbal, that the therapist is not giving up; that he or she keeps up the hope that the patient cannot feel at this stage.

### **Sometimes small things are appreciated**

*I: ... did the doctors help you in any way?*

*P: Yes, they've helped me.*

*I: How?*

*P: The doctors give me pass for going out... (P16:321)*

## 5.2.2 Differences between registrars

Certain patients, because of the length of their hospitalisation, have been seen by several registrars. It was interesting to hear this patient describe the difference between three registrars that had attended to her.

*I: What would you say is that difference?*

*P: Approach. With Dr C I think he was more of a brotherly figure. He presented to be caring more than being a doctor. And he wanted to minimize the dosage of the medication, he didn't want to keep that high dosage. Like with Dr T, Dr T never presented to be listening to your personal needs. He just kept on increasing the dosage until he thought you are speaking sense. So with Dr T the medication was more important than the social, psychological wellbeing. He believed the psychological wellbeing has got to be taken care of by the psychologists. That's what I think. Then with Dr Z, he listened more than he even asks you, he's never asked me which medication I'm drinking, but he was listening to my psychological wellbeing. Like who is looking after you, what do you plan when you get discharged? But he did not ask me: which medication are you drinking, can we change it, until the last moment when the MDT asked him ... hmm ... you can't discharge her on that because she wants to fall pregnant, so we've got to help her fall pregnant by changing the medication; that is then that he spoke about medication.*

(P18:320)

It is intriguing that a medical doctor focussed so much on the psychological wellbeing of a patient, neglecting her medication in the process. Also, that a doctor “*presented to be caring more than being a doctor*”. I suppose this fits in with the modern technological era and a more technological approach to medicine – patients are often not used to a different approach.

Differences can take various forms, but this patient got a bit carried away in her poetic description of doctors:

*Daar is dokters wat so simpatiek is, wat so begaafd is in lewens verhoudinge, wat so volwasse is, wat so emosioneel groot en intelligent is, wat so psigies duidelik dink en psigiatres nie net pille voorskryf nie; maar hulle is meer as psigiaters, hulle is mense. (P19:236)*

There are doctors who are so compassionate, who are so gifted in relationships, who are so mature, who are emotionally advanced and intelligent, who are able to think psychologically so clearly and who psychiatrically not merely prescribe medication; they are more than psychiatrists, they are human beings.

Or differences in age. An elderly patient had much appreciation for an older registrar.

*I: Hy is ook 'n ouer persoon.*

*P: Jy's reg, dit speel dalk ook 'n rol. Ja ... (P11:436)*

*I: He is also an older person.*

*P: You are right; that might also play a role.*

But it is heartening to hear that a junior doctor, in only her second rotation, was able to develop a very meaningful therapeutic relationship with a patient, who described this doctor's ability to get her to talk.

*I: Is there also something else in her personality, the way that she interacts with you?*

*P: Very well, very nice, very calm and patient, she listens. She listened ... and a few times that I saw her I wasn't in the mood to see her, you know. I didn't want to speak about things that maybe bothered me. But the manner she approached the situation made you want to speak about something, not necessarily the problem you know, and then eventually the actual problem was discussed.*

*I: She was able to provide a space for you, where you were ... where you then could actually open up, even though initially you didn't want to.*

*P: I didn't want to, because there was two or three occasions when I got to her and I said, you know what, I don't want to talk today, so is it possible, you know, to excuse me from the session. (P22:272)*

When I asked her how this doctor managed to get her to talk, she responded that the doctor had exerted no pressure on her to talk, but she could sense that Dr P wanted to help her; Dr P furthermore had very good listening skills and gave her space.

*So she knows my history and she's very accommodating and she assists, she is not forceful, she listens, you know. (P22:262)*

The patient explained that 'accommodating' to her meant that the doctor did not forget her; the registrar kept her and her problem in mind.

Yet, interestingly the same doctor elicited a negative reaction with a different patient:

*I: Sy is nou sedert een week jou dokter; hoe sal jy sal jy sê verskil die twee?  
Wat maak haar houding anders van Dr W?*

*P: Dr W het na jou probeer geluister. ... Hy het geluister na wat is fout met jou en hy het probeer om jou te verstaan ... ek weet dit is net 'n week by (die) dokter, ek moet haar seker 'n kans gee, maar sy verstaan nie waardeur ons gaan nie, sy moet seker nog daardeur gaan. (P13:62)*

**Summary:** When asked how the two doctors who had attended to her differed, the patient responded that Dr W listened to you, he tried to understand. The new doctor was with them for only one week; she should probably be given more time, but she does not seem to understand what they are going through, she probably still needs to go through such things herself.

Many reasons can be thought of to explain this patient's negative reaction. Transference means that patterns of relatedness of the past are repeated in the present, so that past experiences influence present relationships (Wallace 1983; Böhmer 2010). Wishes, fears

and expectations that have to do with the past and people of the past are transferred onto present-day people and are acted out. If this patient so quickly formed a negative opinion of this registrar, unconscious factors on her side probably played a role; her past is projected onto the new doctor. These and other complexities of relationships need to be kept in mind. The patient was at least aware that more time was needed.

### 5.2.3 Some further comments on the role of the doctor

*I: En in hierdie proses, is daar nie iets spesifiek waaraan die dokter nou moet aandag gee, behoort aandag te gee?*

*P: Hulle moet kyk of my medikasie werk. En seker maak dat ek is op die regte medikasie, want dis al hoe ek gaan gesond word. ...as ek nie op die regte medikasie is nie, hoe gaan ek gesond word? (P13:326)*

The role of the doctor is to check whether the patient is on the correct medication and if the medication is effective, because that is the only way I shall get better.

*I: What do you think is the role of the doctor?*

*P: The doctor is there to inform you of your illness, and what is it about, and how to treat it, and how to handle yourself, and how to take care of yourself while you are dealing with that illness. He's there to help you through your illness and he's there to motivate you to keep on doing good, instead of relapsing and everything. Yes, I think that's the role of the doctor. (P17:286)*

### 5.2.4 Negative experiences with registrars

#### 5.2.4.1 Consultations once a week

The following quotes speak for themselves:

*...ek hou nie baie van medikasie nie, so om 'n psigiater een keer per week te sien het vir my maar min nut behalwe dat hulle my spreekbuis is by die*

*groep. So hulle is maar net die tussenganger tussen my en die groep. Ek sal eintlik daarvan hou om self met die hele groep te gesels. (P1:262)*

*...I don't like medication, to therefore see a psychiatrist once a week is for me of little use, except that they are my mouthpiece at the team. So they are only intermediaries between me and the team. I would actually like to speak to the whole team myself.*

*P: During the treatment here in the hospital I feel seeing a patient only once a week is not sufficient. Because you're sitting the whole week and the whole weekend, you're doing nothing. But should there be consultation maybe twice a week it could be better. But once a week...*

*I: It's not much, and then you have to wait a whole week.*

*P: Ja, for you to see the doctor again.*

*I: And you don't know what's going to happen.*

*P: Ja ...and to find that the outcome is negative. (P18:408)*

#### **5.2.4.2 And then mostly short symptom orientated consultations**

Patients had the following comments about registrars' attitude and short consultations:

*P: ... you are not interested in my history. You just keep on treating me like a psychiatric patient. You should be concerned about what actually brought me here. (P14:629)*

*I: How do you actually see the role of the doctor? What should the doctor actually do?*

*P: ... the doctor needs to treat patients. That is their duty... Most of them they just think about the drug issue. ... What about the patient's emotional issues? They don't put it into consideration because me, I was really traumatised. (P14:655)*

*I: Het jy soms die indruk dat die dokters nie weet wie die persoon rêrig is nie?*

*P: Ja dokter, dit is asof hulle ... jy is nog 'n pasiënt en jy moet nou gehelp word en klaarkry want die volgende een wag. ... Dit is nie net van "goeiemôre, hoe gaan dit, en wat is jou probleem" en dit nie. Net meer belangstelling. (P9:572)*

I: Do you sometimes get the impression that the doctors do not know the patient as person?

P: Yes doctor, it is as if they ...you are just another patient and you have to be helped, they need to finish, because the next patient waits. ... It is not only about "good morning, how are you, what is your problem?" It is about being interested.

*... it only lasts for about four to five minutes and that's it. Because we don't really talk about anything. It's just "how was the weekend" and then it's "okay you can leave". (P17:204)*

*Yes. I guess that I think that is lacking to the doctors. I think they... whatever the doctors are trained for, they're quick in doing things. Like now, as I'm talking to you (the researcher) right now, I'm open, I'm speaking to you and to me you sound like a psychologist, somebody who wants to know... me, like, more. Unlike if I was talking with my doctor. With my doctor, she was going to be asking me questions that were relating to how I behave inside here and then this and that and then after... I need to get more medication or I need to get less medication. (P5:465)*

Because I, a psychiatrist, had time and was interested in him as a person, I sounded to this patient like a psychologist! For him doctors were associated with interest in his behaviour and symptoms to therefore assess the need for medication.

The following comment was made by a patient who had numerous admissions for a severe psychiatric disorder and had seen many registrars over the years. At this stage, he was much improved.

*I: Het jy enige belewenisse gehad met die kliniese assistent wat vir jou van waarde was? Wat vir jou iets beteken het? Wat jou gehelp het?*

*P: Nie eintlik wat ek nou aan kan dink nie. Jy weet, hulle doen maar net hulle werk en hulle, baie keer dan as hulle my sien, dan sal hulle net vir my vra hoe gaan dit, hoe slaap jy en hoor jy stemme of wat ook al en dit is dieselfde ou vrae elke keer en dan sê hulle, okay, jy kan maar gaan, jy weet dan het ons nog niks eintlik eers gepraat nie. So ek voel die terugvoer is partymaal baie swak wat ek kry. (P1:169)*

**Summary:** The patient said that he could not really remember any meaningful interaction with any registrars. They just do their work and enquire about symptoms; the questions are always the same, and then they say, “OK, you can go”; without even having had a real discussion. The feedback is often very poor.

*I: Did you feel there was a positive relationship with any of the other doctors?*

*P: Not really, sir. I was unable to do that kind of relationship with any of them, sir. (P14:578)*

Maybe it shows that some have forgotten or do not know the name of their doctor.

*P: Yes, the doctor is good, it's alright, the doctor.*

*I: Who was your doctor?*

*P: Dr... I forgot the name ... (P16:251)*

### **5.2.4.3 Other factors that impair the development of a therapeutic relationship**

#### **The frequent rotations of registrars**

*P: He couldn't see that I've relapsed.*

*I: Why couldn't he see that?*

*P: Because I was superficial, and it was the first time he met me, so he couldn't, he didn't know that I've relapsed. And the fact that every time you come to admissions you're assigned a new doctor, new doctor, new doctor.*

*If your doctor doesn't know you, it becomes very difficult for them to read that you have relapsed. (P18:466)*

The above-mentioned comment is linked to the previous comments indicating the lack of a person-centred approach. Frequent rotations and not really knowing the person can lead to more relapses.

*I: Have they explained to you why there are so many different doctors seeing you?*

*P: They didn't, because I kept on complaining why is it that different doctors are ... because each time I come across the same doctor I complained.*

*I: And they didn't give you any proper explanation?*

*P: They didn't really ... (P14:566)*

It is already a difficult situation and it would help if the patients were given more feedback, indicating an understanding for his or her feelings about this.

*I: So in these three months you've seen several doctors? I had a look actually in your file. It must have been about five or six different doctors.*

*P: Yes, I would say so, even seven, because there was one there ...a house officer came to the hospital.*

*I: Are you thus feeling that there is no one doctor really attending to you?*

*P: Yes, sir. (P14:478)*

Other team members, e.g. the social workers and occupational therapists, do not rotate. In the weekly MDT meetings, it is clear that these members know the patients in much more detail, especially their personal history, whereas the registrars are more focussed on the present DSM diagnosis and treatment. The first patient (P1) who had a long history of being treated at WKH emphasised this, saying he would prefer that his social worker is present at his follow-up visits as an out-patient; she knew him and his circumstances the best and has had the most contact with this family.

### **It does not seem as if they care**

This is an opinion expressed by only some of the patients, but it still needs to be heard and taken seriously.

*Ja, want ek dink as die span meer omgee het ... dit voel of hulle net hier werk, so dit voel nie of hulle rêrig omgee nie. Dit is 'n werk, vir hulle dit is 'n inkomste; vir hulle dis nie rêrig om na pasiënte te kyk nie. Vir hulle is dit net 'n inkomste. (P13:464)*

If the team cared more ... it feels as if they are only doing their work, not if they really care. It is a job, a source of income; for them it is not really about caring for patients. For them it is only an income.

*P: ... as dit darem net lyk of iemand belangstel in my, dan sal dit baie help om my positief te hou.*

*I: Lyk dit tans of niemand belangstel nie?*

*P: Nee, dit lyk nie eintlik so nie. (P8:35)*

...if only it looks as if someone shows interest, then it would help me to stay positive. But it does not look like it.

*P: Nee. Hulle vra nie eintlik uit oor dit nie. ...ons is baie ongelukkig, maar dit lyk nie of hulle omgee nie. (P8:107)*

No, they don't ask about it ...we are very unhappy, but they don't seem to care.

### **You are only a number**

As with the previous comments, this comes from some of the patients who however also differed in their opinions regarding different registrars.

*Want die dokters het, hulle het baie pasiënte en hulle weet nie, jy is maar net nog 'n nommer. (P2:215)*

The doctors have many patients, you are only another number.

*I: What was the most negative experience for you in hospital?*

*P: The previous time when I was here it was ...I was also just maybe a number. (P22:368)*

### **Body language**

Patients observe us and are sensitive to our body language, as expressed by this elderly man.

*Ek is baie goed daarmee om lyftaal ...sy het eenvoudig net verveeld vir my gelyk, jy weet, maar nog 'n pasiënt te sien en dan, ek weet nie of dit nou 'n gewoonte van haar was om haar hare te trek nie, maar dit was vir my uiters irriterend. En haar manier van praat was so monotoon, jy weet ... Die gebrek aan belangstelling, absoluut ja. En dit het gelei tot 'n verkeerde diagnose. (P11:306)*

I am good with body language ...she just looked bored, another patient to see; and then, I don't know whether it was a habit of hers to pull her hair, but to me it was very irritating. And her way of talking was so monotonous... And not enough interest, yes. And that led to a wrong diagnosis.

### **Reactionary**

If there is a lack of containment, if things become too much, we often act in a reactionary way; we *react* to the patient, we do not manage to keep a stance of acceptance. In the following quote, the patient expresses how she experiences the doctors as positive if she is well and not manic. This is listed under negative experiences, because it indicates a negative stance and lack of containment she experienced from registrars during her periods of severe illness.

*I: Wat was dus vir jou die mees positiewe belewenis met die dokters?*

*P: Wanneer ek nie manies is nie. Wanneer ek as buitepasiënt gaan na buitepasiënte toe en ek is gefokus en ek is besig met interessante dinge in my lewe en ek is kreatief. Dan sê ek vir hulle wat ek doen en dan is hulle positief. (P19:250)*

**Summary:** For her the most positive experience with the doctors was when she was well during her follow-up period and showed them her creative work. Then they were also positive.

### **Registrars having ‘no say’, but having to consult the team: the interaction between registrar and the team**

The interaction between registrar and team can be problematic as shown by this quote:

*I: How do you feel about Dr Z?*

*P: He is a good doctor, but I’ve just realised that he can’t make decisions by himself.*

*I: Oh, he has to go back to the team.*

*P: Ja.*

*I: So that limits things.*

*P: But he is a very good doctor. He gives you time you know and he is not only concerned about your treatment, he also is a psychologist in his own nature, because he will talk to you, what is bothering you, how are you going to solve it, you know. He is really a good doctor. (P18:306)*

It can have a very negative effect on the therapeutic relationship if the doctor is perceived as someone with no real say, only an extension of the MDT.

*Ek dink die dokters het te min regte. So hulle, hulle kan nie sommer net besluit nie. Hulle moet elke keer, moet hulle eers na die span toe gaan en toestemming kry. Ek dink die dokters behoort hulle eie inisiatief te kan gebruik om te sê, okay, ek gee jou ’n pas, sien jou oor ’n week, of sien jou oor twee weke. Hulle het nie genoeg mag as dokters nie. (P2:235)*

I think the doctors have too few rights. They can’t just make a decision. They always have to ask the team and get permission first.

*P: ... and sometimes that doctor will tell you: “I’ll discharge you next week”. But then he goes to the MDT, and they will say no, not yet. You know, that’s what happened to me this time around. I was supposed to be discharged*

*last week, but when you're waiting and the MDT says no ... So it's waiting.*

*You wait and wait and wait and wait the whole day.*

*I: It must really be difficult to wait for so long.*

*P: It is. (P18:56)*

### **Not keeping promises**

A very obvious and serious mistake.

*Eenmaal 'n week, en dan sê hy vir my ek sal jou Woensdag sien en dan sien hy my nie Woensdag nie. Drie weke lank sê hy vir my so, ons sal hom Woensdag uitsorteer dan doen hy dit nie. Dan sien ek hom weer Maandag dan sê hy Woensdag en dan kom hy weer Maandag dan sê hy Woensdag en dan kom hy weer Maandag dan sê hy Woensdag, dan kom hy weer Maandag dan sê hy Woensdag, dan kom hy weer Maandag dan sê hy Woensdag. (P19:596)*

**Summary:** He saw her for three weeks only on Mondays and every Monday he promised her that on Wednesday he would come to sort out her problems, but that never happened.

### **Not dressing well**

The dress code of physicians in South Africa has become very relaxed over the last 20 years. Doctors should be aware that certain patients notice this and are affected by it, as expressed by this patient:

*P: Ok, ja, other ways, the way of they're dressing. They don't dress like medical doctors. Seriously. They don't dress well. ...*

*I: How should they dress?*

*P: They must dress formally ... they just dress casually to job. No, you must dress the proper way, appropriate way. We in Nigeria, we, the doctors where you see respect is coming. Even with us you know it's a doctor. You just know this is a doctor without the doctor telling you because of the way he dressed. ...*

*I: What effect does it have on you if the doctor is casually dressed?*

*P: Heh, heh, heh, heh. ... they are not presentable actually. ... Ja, when somebody's presentable then you can listen to the person. ... It shows that you are more responsible ... they will want to respect you, listen to you, do everything. (P14:909)*

### **A feeling of helplessness**

Feeling helpless is often the consequence of not being kept in mind by the doctor as the following quotes show:

*... my doctor is the one that's going to see to it that I get to be on the open ward, where I will be able to wake up probably around the time 5 and take a shower and then do things normal like any other person would do. Yes, but now it doesn't happen like that, eish, it becomes a problem. I feel very much more at the mercy of our doctors .... (P6:55)*

*I: ... It sounds to me as if you feel threatened, or anxious, or helpless.*

*P: Helpless ja. Helpless because the doctors are the ones who decide.*

*I: So you have no say. There is nothing you can do.*

*P: No, there is nothing you can do. A group of experts are just there to decide for you what is supposed to happen. And it looks like you have no say. (P18:81)*

*Hulpeloos en magteloos, daar's dit. (P19:480)*

*Helpless and powerless, that's it.*

After having been in a closed ward for five weeks this patient (ap psychotic and not aggressive when I interviewed him) still had no clarity about his diagnosis and reason for hospitalisation.

*But no one has ever tried to find out really deep why I'm here, because with me I think it's different, I don't think that is the reason why I'm here; it's more... I think it's more in the sense that I'm here to assist others, other*

*patients to recover. I'm not just here for myself to be okay only, but to also, to assist other patients to become better and be out of here ... it is really getting on my nerves, I would say. But for the fact that I tell myself that I should be patient, because the doctors are the ones who know better ... (P7:55)*

It is surprising that he ends with accepting that the doctors know better. I could see no reason why he had to stay in a closed ward for so long, but would ascribe it to bad care.

### **5.3 THE REST OF THE MULTI-DISCIPLINARY TEAM (MDT)**

The findings about the nursing staff and registrars, part of the MDT, have already been summarised; this section concerns itself with the rest of the MDT: the psychologists, occupational therapists, social workers, pastoral counsellor and consultants.

#### **5.3.1 General comments about the team**

Questioned about what they considered to be good care in a psychiatric hospital, several patients mentioned the important role of the MDT:

*P: Good care is... would be as in, you've mentioned the five people that play a role in the lives of people that are patients here, they need to be all of them, they need to be known by the patients. The patient needs to know that I have five different elements that can be used in making my life better, you know, so then make use of them. If they don't see a doctor, they wouldn't mind that much, they would wish to see, probably, a psychologist, or the other ones that you have mentioned, a social worker if the person feels this problem's more of work... I mean, home related you will see a social worker, yes.*

*I: So good care would mean to involve all of those people.*

*P: I think that would be good care, yes. (P5:473)*

*I: Wat sal jy dus sê in die vyf weke wat jy nou hier in Weskoppies is vir jou uitgestaan het in terme van jou behandeling? Wat was rêrig vir jou sinvol?*

*P: Wel, die feit dat 'n mens met 'n professionele span werk. Dit is nie net jou psigiater nie. Dit is jou sosiale werkster, jou sielkundige, jou arbeidsterapeut en elkeen van hulle het 'n bydrae gelewer en 'n absolute positiewe bydrae. (P11:72)*

**Summary:** Being treated by a professional team makes treatment special and meaningful; it is not only a psychiatrist. All members of the team make a positive contribution.

*I: But can there be something or is there something positive about the team approach?*

*P: Ja, there are positives. I think whatever decision this consultation, it's different consultative, it simply means it's not individualistic, whoever makes decisions has consulted with multiple consultants.*

*I: And is there something positive in that?*

*P: There should be, because I think the decision is more stronger than the individual. (P18:562)*

*I: Hoe sou jy dus goeie psigiatriese behandeling beskryf?*

*P: Ek sou sê dit is pille nê, medikasie plus 'n span. 'n Span wat saamwerk. Nie net 'n sielkundige nie, maar 'n geestes persoon. Nie net ook eenmaal 'n week nie, maar wanneer die besoektyd daar is, moet die geestelik opgeleide persoon ook teenwoordig wees. (P19:754)*

**Summary:** Good psychiatric care consists of medication and a team that cooperates; this will include a psychologist as well as a spiritual counsellor.

However, patients can also feel threatened by the multi-disciplinary team:

*I: Do you feel that these groups of experts are on your side, or do you sometimes feel nearly as if they are the opposition?*

*P: While you are in hospital, because you're just fit to leave, you feel like they're not on your side, they just want to keep you. But once you're discharged, you can see that these people were for you, even if it took a long time.*

*I: Is it just only afterwards that you realised that?*

*P: Ja. ... Ja it's strange that for once I feel like they're still on my side.*

(P18:92)

Or negative about the team:

*I: Dink jy dat jou span enigsins weet hoe jy rêrig voel?*

*P: Nee, want hulle praat nooit met my nie. (P8:93)*

*I: Do you think the team knows at all how you are really feeling?*

*P: No, because they never talk to me.*

About the role of the registrar in the team, a patient had the following to say:

*I: Hoe sien jy nou binne hierdie span die rol van die dokter? Dr Y. Wat is sy rol binne hierdie span?*

*P: Wel, uit die aard van die saak moet alle besluite, moet deur die hele span goedgekeur word, want hy het die voordrag gelewer met my, so hy het baie meer tyd met my gespandeer as die res van die ... ander lede van die professionele span en op die einde het sy voordrag oor my ... ek dink dit was die deurslaggewende faktor gewees, so hy was absoluut, so hy was absoluut, ek sou sê, die spanleier gewees. En die man wat die ander mense oortuig het dat ek nie manies is nie. So ek sien hom as 'n spanleier ek mag verkeerd wees, maar hy het 'n baie groot rol gespeel, want hy het baie meer tyd met my gespandeer.*

**Summary:** The patient says that the team obviously has to approve all decisions, but the registrar did spend the most time with him; his report on the patient (in the ward conference) was of cardinal importance and the patient thinks of the registrar as being the team leader. The registrar played

an important role, because he spent so much time with the patient. “He was absolutely the team leader.”

### 5.3.2 Psychologists

Psychologists are seen in a different light than doctors; they are described as more interested in the personal history of the patient, talking more, exploring underlying factors that could have led to or contributed to the illness and understanding the mind better.

*... but a psychologist would understand further, would just go beyond that and want to know why do you... has this and this and that happened ... ?*  
(P5:397)

*I: So a psychologist would try to understand more the underlying reasons.*

*P: The underlying reason, thank you, yes, that's what I look. (P5:407)*

*I: Who of the team would you actually then like to see, if it was your choice?*

*P: If it was my choice, the psychologist. ...*

*I: What would be your reason?*

*P: My reason would be that he will... or she will do more the stage of the things that I would be talking with, with her or with him. She will go beyond and find out even more about that. If I come back and I tell him, look, this and this has been happening and I don't understand it, then he will do more research on that and then when... next time we meet, probably he will be having the answers. Yes, actually it will be more like somebody I would be really relying on. (P5:487)*

*I: ...you didn't finish your sentence, you said a psychologist knows better about?*

*P: About how the mind works. (P5:383)*

This patient described needing a psychologist to be able to express her emotions:

*... maar ek voel tog net partykeer of ek 'n bietjie behoefte aan 'n sielkundige het om uiting te gee aan jou emosies. (P12:60)*

...sometimes I feel I need a psychologist to be able to express my feelings.

Another patient felt more positive about psychologists than about psychiatrists. This patient, however, had no insight into his problem and the need for medication. (He has had several severe manic episodes with psychotic features.) To prefer seeing a psychologist can also be part of the denial of the problem:

*Maar ek voel meer positief oor sielkundiges as ook psigiaters, want psigiaters behandel ons met medisyne, en ek hou nie van medisyne nie. Ek sal eerder eerder een keer 'n week 'n sielkundige sien as 'n psigiater, wat net die heelyd vir my wil pille gee. (P1:229)*

But I feel more positive about psychologists than psychiatrists, because psychiatrists treat us with medication and I do not like medication. I would rather see a psychologist once a week than a psychiatrist who wants to prescribe medication all the time.

Participating in group activities had been valuable for this patient, he missed that:

*... 'n sielkundige ... het groep besprekings gehad met ons, lewensoriëntering, fokus op die toekoms wat jy gaan doen; en ek moet sê dit was baie, baie insiggewend gewees. Dit was 'n weeklikse sessie, waar sy almal betrek om 'n ronde tafel en dan het ons gepraat oor lewensvaardighede en emosies en gevoel en denke en die goed. En ek voel dit is nogal iets wat kort hier... (P12:20)*

...a psychologist had group discussions with us, life orientation, focus on the future; I have to say it was very insightful. It was a weekly session, sitting at a round table, and then we talked about life skills and emotions and feelings and thinking and such things. I feel this is missing here...

However, there were also negative reactions. Junior psychologists conduct most of the psychotherapy with patients. Even though they are under supervision of consultant

psychologists, the psychotherapy can be a challenge for them – and the patient. A lack of experience and insight on the side of the psychologist can lead to situations such as the following:<sup>12</sup>

*I: Wat het gebeur toe jy die sielkundige se venster uitgeslaan het?*

*P: Hy het gekarring oor my seun se dood en hoe meer ek vir hom sê ek ... ek weet nie, toe sê hy nee, maar ek moet weet. Toe sê ek, ek weet nie, toe sê hy maar ek moet weet en toe het 'n woede oor my gekom en ek wou hom eers aanrand en toe slaan ek die venster uit. Toe sluit hulle my toe. (P9:350)*

*I: What had happened when you broke the window of the psychologist?*

*P: He carried on about my son's death and the more I said, I do not know, the more he said but I should know. When he repeated that again, I became furious; I initially wanted to hit him, but I then broke the window. Then they locked me up.*

Another aspect of psychotherapy to learn is to know when to confront the defensive behaviour of a patient (e.g. interpreting long working hours as running away from family problems) and when to be supportive (e.g. showing understanding for not wanting to deal with an issue right now):

*P: Ek het 'n sielkundige gesien, ek gaan eerlik met jou wees, ek hou nie van sielkundiges nie. Ek kom nie oor die weg met 'n sielkundige nie, ek kan nie met 'n sielkundige praat nie.*

*I: Hoekom dink jy is dit so?*

*P: Want daar is goed waarmee ek gedeel het en dan krap hulle, toe wou hulle hulle probeer oopkrap. Ek het daarmee gedeel en dis verby, dis in die verlede, maar nou wil hulle daai roof afhaal en hulle wil die seer weer uithaal waarmee ek 'gedeel het'. (P13:268)*

*P: I saw a psychologist, but to be honest I do not like psychologists. I do not get along with them, I can't talk to them.*

*I: Why do you think is that the case?*

---

<sup>12</sup> I discuss this as an example of a lack of containment in Section 9.4.

P: Because there are things I have dealt with and then they dig it up; closed wounds they want to open. I dealt with it, it belongs to the past, but now they want to scratch off the scabs and want to get to the pain that I have dealt with.

In our MDT meetings, I at times realised that the intern-psychologists, who are primarily responsible for ward patients, struggle to cope with the number of patients they have to see. They are young and inexperienced and, although they are in supervision, their task is not easy.

### 5.3.3 Occupational therapists

Occupational therapists' role in a psychiatric hospital are varied and important. OTs promote physical and mental health through engagement in occupational and other activities. In WKH they offer assessments for different occupations and activities of daily living, furthermore individual or group activities in which attention is given to the learning of life skills and rehabilitation.

Their therapeutic influence was valued by patients:

*I: Wie in hierdie tyd in Weskoppies was dus, het dus vir jou die mees belangrike persoon geword?*

*P: Dr Y, en dan sal ek ook sê M, die arbeidsterapeut ... sy is ook baie baie positief en sy het my geweldig ondersteun ... (P11:175)*

*I: Who during your time in Weskoppies became the most important person to you?*

*P: Dr Y, and then also M, the occupational therapist ...she is also very positive and was very supportive...*

*I: Goed, maar in terme van die betrokkenheid by jou, wie van die span was rêrig betrokke?*

*P: Nee, dit was die OT's die meeste, absoluut, hulle is 'n wonderlike mense; die feit dat ek elke dag OT gehad het en hulle stel absoluut in jou belang en dit is lekker om met hulle te kommunikeer en om met hulle te gaan gesels. (P12:25)*

*I: OK, but in terms of being involved in your care, who of the team was really involved?*

*P: It was mostly the OTs; definitely, they are wonderful people; the fact that I had OT every day and they are really interested in you and it is nice to communicate with them and to be able to talk to them.*

*I: You mentioned three things. The medication, your father's support and the church people's support. So was that in this time here actually for you the most important?*

*P: One of the most important things was going to OT, it helped me a lot as well. (P17:110)*

*Yes, the OT, it was important to me to go in the OT, I feel very better. (P3:71)*

#### **5.3.4 Social workers**

The social worker is seen as someone interested in the wellbeing of the whole family; someone who does not rotate as the registrars do, but stays in the team and therefore has the opportunity of accompanying the patient and his or her family on the road to recovery.

*I: Maar jy het I as eerste persoon genoem. Dit klink asof jy die graagste by haar sal opvolg.*

*P: Ja, want sy is mos 'n 'social worker'... so sy is, sy moet mos kyk na die familie se belange, die gesin, jy weet en sy kan met E kommunikeer en so kan E vir haar sê, jy weet, hoe gaan dit met my, of ek myself gedra. Of ek genoeg slaap en daai tipe van ding. ... Sy ken ons ook al lank. Sy ken ons al van 2009 af. Van ek die eerste keer hiernatoe gekom het. ... Ja, dit is meer 'n persoonlike vlak, want die dokters is so besig ... sy is baie besorg oor die pasiënte en die 'wellbeing' van my en my gesin. Jy weet hulle is mos*

*'social workers' hulle stel baie belang in die gesin en almal moet gelukkig wees en so aan. (P2:189)*

**Summary:** He would like to follow up with the social worker, who has known the family for many years. She would communicate better with his wife and it would be on a more personal level, since doctors are so busy. Social workers are interested in the happiness of families.

*X ... is 'n mens mens. Sy sal vir jou alles doen wat sy vir jou kan doen. (P13:496)*

X (the social worker) ... is a warm-hearted person, focused on people. She will do everything for you that is possible.

Social workers are usually appreciated for their help, but can at times also be a source of anxiety, as illustrated by the following comment:

*P: Ontstel dit jou dat sy weet?*

*P: Dit het.*

*I: Hoekom?*

*P: Want welsyn werkers vat jou kinders van jou weg en as hulle nou ... nie my kinders nie, maar as hulle nou van my meisiekind se probleme weet en goeters, kan hulle nie iemand aansê en my meisiekind se lewe nog verder gaan omkrap en haar kinders wegvat van haar nie? Om daar te sit en vir haar te sê, ja ek was daar gewees, ek is nou daar, ek het nie 'n huis nie, ek het nie 'n werk nie. Noem dit valse trots ... ek nie gevra vir 'n 'social worker' nie, alhoewel mens het geld nodig. (P21:285)*

**Summary:** The patient's view of social workers is that they take your children away. She is worried that they might find out about her daughter's situation and problems and take away her children, which would make things worse. It is also degrading to tell a social worker about your problems, about not having a house or a job. She didn't ask to see a social worker, but on the other hand she is in need of money.

### 5.3.5 The pastoral counsellor

For some pastoral care is of great importance:

*I: Wat sê jy dus was vir jou die mees belangrike belewenis in hierdie vyf weke?*

*P: Dat ek by dominee D kon uitkom. (P21:158)*

*I: What was for you the most important experience in these five weeks?*

*P: That I could see pastor D.*

Many patients wish to see the pastor, but since the hospital only has one pastor, his availability is limited:

*...maar ek dink as 'n mens in 'n mate kan kry as die dominee jou dalk net een of twee keer kan besoek. (P11:270)*

*...if it would just be possible for the pastor to see you once or twice.*

*...wat vir my redelik sinvol was is dominee D kom een keer 'n week na die saal en dan doen hy so 'n meditasie groep. Dan bid ons en dan sit ons so in 'n kring en dan mediteer ons en dan gesels en dan sê ons vir hom jy weet wat se prentjies of wat se woorde het jy ontvang in jou meditasie. Dit is lekker. Dit is stimulerend en dit is goed ... (P2:127)*

*...the weekly visit by pastor D was meaningful; he holds a meditation group. Then we pray and sit in a circle and meditate and then we discuss our experiences during the meditation. This is nice. It is stimulating and good...*

### 5.3.6 Other members

Consultants were rarely mentioned, and if so just in passing, e.g. mentioning them in their function as head of a ward conference. Only once did a patient mention that he was impressed with how a consultant psychiatrist had handled the ward conference (P11:338).

A few patients made comments about me as researcher. They appreciated that I had time for them and that I tried to understand their experiences as shown in the following comments:

*... like now as I'm talking to you right now, I'm open, I'm speaking to you and to me you sound like a psychologist, somebody who wants to know the... me, like, more. (P5:465)*

*I: ... you didn't have such a therapeutic relationship with any team member.*

*P: Yes.*

*I: How do you think that that affected you, that you did not have such a therapeutic relationship?*

*P: I think it has blocked me from growing actually. It has not allowed me to grow or to even venture enough to other possibilities that ... could be underlying in my condition that I could sort out and be able to deal with, because there's a lot that is not being said, that I haven't spoken about. But since I have been talking to you, I think somehow a certain part of me just is feeling good in the sense that there is somebody who understands me much better now and whom I can talk to and interact with. (P7:57)*

*I: Het jy nog enige ander gedagtes gehad oor gister se onderhoud en al die vrae?*

*P: Ek het baie geleer uit die onderhoud. Ek het baie oor myself geleer... (P20:38)*

*I: Did you have any further thoughts about yesterday's interview and questions?*

*P: I learned a lot from the interview. I learned a lot about myself...*

## 5.4 OTHER PEOPLE INVOLVED

### 5.4.1 Fellow patients

Being a patient and especially being admitted to a hospital is for most a difficult experience, causing anxiety and uncertainty. Staff members can seem intimidating and it is understandable that patients then look to people in a similar position for support. Fellow patients can become very important, as expressed in the following quotes:

*I: So fellow patients have for you been the most important actually, if I understand you correctly.*

*P: Yes. Fellow patients they have been most supportive and they've been amazing to me. That's how I see it. (P5:139)*

*I: But you told me last about those two patients, the fellow patients. Would you say that that was actually the most meaningful interaction?*

*P: Yes, to me it was the most meaningful interaction. (P7:33)*

*I: Has any specific person become important to you in the time that you've been in the hospital?*

*P: Important in which way?*

*I: That you say, that person really helped me, or that was a meaningful interaction with that person.*

*P: Yes I had a friend whose name was R, but he left... (P17:214)*

*I: As jy dus nou weer daaroor moet dink - in hierdie sewe weke - is daar enigiemand wat vir jou rêrig belangrik geword het? Enige persoon. Enige iemand in die hospitaal?*

*P: M. Soos die pasiënt M. ...*

*I: Sy is vir jou die belangrikste van almal, van die susters, dokters, enigiemand; M is vir jou die belangrikste.*

*P: Ja. Sy is altyd daar vir my. Ons is daar vir mekaar. Ons het regtigwaar ... ons kyk na mekaar en as die een iets nodig het, kyk die een na mekaar.*  
(P13:366)

**Summary:** The patient M was to her the most important person in the hospital; they were always there for each other and helping each other.

*I: Jy het dus glad nie die dinge wat jy met M bespreek het met die staf bespreek nie? Nie in sulke diepte nie?*

*P: Nie in sulke diepte nie, nee.* (P13:458)

**Summary:** The patient did not have such a deep relationship with the staff as she had with the fellow patient M; she did not discuss her problems with the staff as she did with M.

For some, not only a nursing sister, but also a fellow patient can feel like a mother figure:

*...she's also a patient. They also call her my mamma, so I accept her. Yes, it's my mamma.* (P14:1001)

*Sy is soos my ...ja, ek dink sy is dalk 'n ma figuur vir my.* (P13:412)

*She is like ..., yes, I think she is like a mother figure to me.*

Unfortunately, for this patient staff members were only there to dispense medication, but to fellow patients they could talk; fellow patients were important:

*P: The staff members, they are just there to give medications. Though some of them, mostly in this ward, they are concerned about your issues. But you can't be talking to them every now and then ... you can confide in the patient, you can talk, you can laugh and play with the patient. ...*

*I: Would you thus say, did I understand that correctly, that the fellow patients were for you the most important?*

*P: Yes.* (P14:733)

Fellow patients are described in a very positive light. Staff members are in the previous quote depicted as if they do not really care and are only there for administrative functions. However, it is unrealistic to expect staff members to always be immediately available. To have such demands can be an expression of the underlying psychopathology of the patient.

The following quote is unusual, since the patient, a 30-year-old woman studying for her master's degree in the arts (psychology is also one of her subjects), finds not only closeness with another patient, but is of opinion that this person will give her the correct advice, although she also describes the mental capacity of this patient as 'sometimes affected'. Such an attitude could also be part of the defensive behaviour of the patient, of not wanting to be confronted with whatever inner conflicts she suffered from.

*I: Do you have anyone in the hospital with whom you feel you've got a close relationship?*

*P: Ja.*

*I: Who?*

*P: It's a lady who speaks the same language and she is older than me, old enough to be my mother. She is a patient, but I can relate also to the lady who works with the nurses.*

*I: But who is the closest?*

*P: It's the patient.*

*I: The patient. Why that patient?*

*P: It's because she is older than me and I can relate to her for advice. I'm not scared to tell her everything or how I feel, because she is not judgmental. She is going to give me the correct advice, although sometimes I feel her mental capacity is sometimes affected. Even when I relate to her, she doesn't reach me at different levels, but she is understanding. She keeps my secrets, because confidentiality is very important. She keeps my secrets. ...*

*I: But you said she doesn't reach your deeper levels; do you feel that a real deep understanding is somehow missing?*

*P: Ja, I feel ... sometimes she is doesn't understand what I'm saying. Her response is maybe inappropriate at some instances. (P18:166)*

Why is such a person the closest to her? Is she similar to a non-judgmental and accepting mother figure? <sup>13</sup>

Helping other patients can also mean a lot:

*P: Ja, en hierdie keer, nou in saal 35 was daar iets besonders, baie besonders en dit was dat ek kon 'n verskil maak, nie net in my eie lewe oor my eie toekoms nie, maar ... mense kon tot my keer as 'n vriendin en raadgewer en dit was 'n groot uitdaging, want jy moet sterk bly om jousef dan te hou en jy moet sterk bly om iemand anders aan te moedig en op te hef en te inspireer.*

*I: Sê u dus dat iets besonders met hierdie opname was 'n tipe verhouding wat ontstaan het met mede pasiënte?*

*P: Ja.*

*I: Waar u kon help.*

*P: Ja, baie. (P19:40)*

**Summary:** During this admission she could be of help to other patients; she could be supportive and inspiring and this meant a lot to her.

Sharing with fellow patients fulfils an important supportive function:

*We're a small group, we've got different problems, not all of us, you can see when we are sick, some of us look a little bit more sick than the others. But you can see the change after two or three weeks. The group sessions, interaction, discussing your problem and sharing you know, you open up, okay. (P22:186)*

In a closed ward, fellow patients can be a source of hope. Being locked up for a long time is difficult to bear; having other patients who are there even longer can help, perhaps in the knowledge of not being forgotten and that one will get one's turn.

---

<sup>13</sup> | discuss this patient and this relationship in Section 9.3.3.1.

*...even the ones that are younger than me, they look up to me, some of them, that he is still here, then it means our time is not through yet. Maybe if he goes, then they will be knowing... they will be knowing that their time is going to come as well. (P5:145)*

The same patient described other patients as role models. These are patients who were admitted before him and who managed to cope with their difficulties. Noteworthy is that those role models stay role models, even when acting strange!

*I: Are you saying that even your role models are doing strange things?*

*P: Yes, they do act strange when the time ... they feel that the time is now overdue.*

*I: Like what, what do they do?*

*P: They make funny noises and they sometimes grab on the, I don't know which one grabs on the doors and banging, I don't know who is doing that, but I think because of that, because of the timing they do strange things. The other one in the morning she makes a cock noise like a cock just to show that it's already morning now, please open up for us.*

*I: Your role models also make funny noises or act strangely, but you still say they are still your role models?*

*P: Yes, yes.*

*I: Mr T and ...*

*P: And Mr M yes. I still say they are, because when I look at them I feel like I will be okay, because they are role models in a sense that they are taking their medication, so if they're taking their medication it means something good is going to come out of them taking their medication. So if I stick to taking my medication maybe something good might come out as well. (P6:305)*

*I: Why are they role models? What makes them so special?*

*P: Yeah, to me it's because they're able to adjust themselves to whatever conditions these... this place has made them change to experience, so... but they are adjusted themselves in such a way that they did not worry a lot*

*about time like I do. They just see each day as it comes and as it goes without worrying about what are they going to do when they are out. But myself, I worry about what am I going to be doing when I'm out, thinking about my family, thinking about my friends and all of that, because I have a life out there. (P5:112)*

The following statement, however, expresses however more of an awareness of the difficulties in expecting support from patients:

*Mede pasiënte ... hulle is self op 'medicines', hulle kry ook swaar en jy kan ... hulle kan nie jou laste dra nie, want hulle dra ook net so swaar laste. Net so swaar, indien nie swaarder nie. (P20:200)*

*Fellow patients ...they themselves are on medication, they also suffer ...and can't carry your burden, because their own is already heavy. As heavy, or perhaps even heavier.*

#### **5.4.2 Other staff: Cleaners**

Meaningful connections and interactions can also happen with cleaners, who can be of great support to a patient.

*P: ... sometimes I speak to the sisters.*

*I: Is there a specific sister or specific sisters?*

*P: Actually the cleaner.*

*I: The cleaners?*

*P: Ja.*

*I: Do you speak more to the cleaners than to the sisters?*

*P: Ja.*

*I: Different cleaners or one or two specific ones?*

*P: One specific cleaner.*

*I: Why her?*

*P: Because she speaks the same language as me and she also lost her husband at the same month that I lost my son. So we feel connected.*

*I: So there is something that you can share. That pain that you have worked through. (P18:188)*

Several patients, however, also commented on cleaners interfering with the patients, getting involved in conflicts and not keeping to their role:

*Yes, sir! ... I had to clean the vomitus. ... Where are the cleaners? The cleaners, eh, a nurse (is) supposed to supervise the cleaners. Here they don't supervise cleaners. All the cleaners are not doing their job. ... The cleaners and the nurses are the ones supervising patients. How come, cleaners are supervising patients? (P14:368)*

#### **5.4.3 Medical students**

I think that medical students do not realise what a difference they can make to a patient:

*... en dan snaaks genoeg daar was 'n paar mediese studente ook. Die een het gister vir my nog twee tydskrifte gebring. Sy is nou in haar 6de jaar mediese student en sy is absoluut 'n juweel. En sy sê sy ken my van X af, en sy is nog al die pad 'n deel van die ...sy het ingesit op die konferensie en gister toe kom, net na u hier was, toe bring sy vir my tydskrifte. (P11:177)*

*...and then, strangely enough, there were also medical students. The one brought two magazines for me yesterday. She is in her sixth year and a real gem. She knows me from X (the referring hospital) and she has all the time been ...she sat in on the conference and came yesterday to bring me the magazines.*

Students sit in at times when a patient is seen by the registrar; this can make such a consultation more difficult for patients:

*I: Was daar vir jou enige negatiewe belewenisse met hom?*

*P: Nee.*

*I: Niks nie?*

*P: Dis 'n bietjie 'scary' as al die mense so rondom jou sit, studente, dis vir my 'n bietjie...*

*I: As jy vir hom sien saam met al die studente.*

*P: Ja dis, dit voel vir jou jy sny jou binneste oop, en dit is makliker om met een persoon te praat.*

*I: Dit is so. Was dit altyd gewees dat hy jou saam met die studente gesien het?*

*P: Ja.*

*I: En hoeveel studente sit dan by?*

*P: Ek kom kop onderstebo in en ek tel nie. (P21:230)*

**Summary:** It is scary to see the registrar with the students present. You feel as if you are cutting your innards open; it would be easier to talk to only one person. I just sat with my head bowed; I don't know how many students were present.

*I: Dink jy dus dat in so 'n situasie, met studente ensovoorts by, dink jy dat dit moontlik is om 'n professionele goeie verhouding op te bou met jou dokter?*

*P: Nie maklik nie. Nie maklik, baie moeilik, want daar is elke keer ander studente en hy of sy is so gespanne om 'n professionele dokter te wees voor hierdie student. (P19:714)*

**Summary:** It is not easy for a professional relationship to develop; with every visit there are new students and the registrar is tense in front of the students, trying to be a professional doctor.

## 5.5 STUDYING OF HOSPITAL FILES

When I read notes made by team members in the files of patients, the detailed notes made by the occupational therapists of their very comprehensive assessments struck me. The

registrars' admission notes and the notes for the presentation at ward conferences are also very thorough. In their presentations at ward conferences, registrars will give a very detailed description of the patient's presenting problems, psychiatric, medical and life history – in general very good presentations, as one would expect in an academic institution. I found the follow-up notes of the registrars, however, mostly short and focussed on present mental state assessment and medication. There is very seldom anything written about the personal sphere; either about the patient's personal life, or about the registrar-patient interaction. These notes could be described as 'generic' notes that could be applicable to any patient with a similar diagnosis.

I chose the file of patient number six as an example. This patient had described his registrar as being very involved and they had had long consultations. He expressed great appreciation for his registrar. The file included the usual admission notes, medical examination, risk assessment, special investigations done and the follow-up notes by the nursing staff, registrars, or medical students. The notes made by nursing staff in his file were, as usual, very detailed; every day there were three to four notes on observations made in the morning, afternoon and evening. These notes included observations on his behaviour, sleeping pattern, appetite, self-care, by whom of the team he was seen on that day and the medication used.

The registrar's follow-up notes consisted of:

- Short notes on present symptoms that the patient complained of.
- Notes on his mental status at that stage.
- A short comment on treatment, e.g. "Patient stable, continue on medication".

Only one note was longer and included a few facts of the patient's life. The notes in this file are typical of files in WKH. The registrars are taught psychodynamic principles and a psychodynamic formulation, which is a description of the unique inner life of a patient and how this relates to his mental problems, yet in the registrar's presentation to the ward conference, a nine page typed document, there was no psychodynamic formulation to speak of; nothing of this kind was also written down in the follow-up notes.

In this file, there were no notes from a psychologist, although it was noted that in the ward conference the decision was made that he would also consult with a psychologist. The psychologists usually prefer to keep a separate file for reasons of confidentiality, but should make brief notes in a patient's usual file.

I included the studying of hospital files in the planning of this study, but apart from the documentation of the initial interview with the patient, not much other information was gleaned from these files, because of the short follow-up notes.

## **5.6 SUMMARY OF CHAPTER 5**

In this chapter, I described the interaction of patients with all the different members of the MDT, the highs and lows. Included in this chapter are also descriptions of interactions between patients and fellow patients, patients and cleaners and patients and medical students.

The importance of relationships is illustrated in many ways. It is not only members of the MDT who can become important, but also cleaners, medical students, or fellow patients. The relationships with fellow patients can take various forms, e.g. friendship, advisor, mothering and being mothered. Patients are not always very discriminate about with whom they connect, probably an indication of how important it is *to* connect. Not being judged and confidentiality is important. It is also very interesting to note that fellow patients can be role models and a source of hope.

The studying of the hospital files was disappointing in the sense that the information about the personal life of the patient is very minimal and provides very little information about who this patient is. By only reading the files, I would not be able to picture the patient. Furthermore, there is no information about what happened in the interaction between the patient and team members. For example, how did the registrar feel about the patient, which feelings surfaced in the meeting, how it was to be with the patient? Exhausting? Or an experience of collaboration? Or did the registrar notice defence mechanisms used by the patient, such as splitting? How did that affect him and the treatment process?

Of course, the information in the file will never capture the full detail of what happens in the professional interactions between patient and caregivers and hopefully much more happened than what was recorded in the file.

## 6 HOLDING AND CONTAINMENT - OR THE LACK THEREOF: THE SECONDARY FACTORS

In Chapter 6 I address the ‘secondary factors’, listed in the seventh model, that impact on the hospital community.<sup>14</sup>

### 6.1 RELIGION, SPIRITUALITY, CULTURE AND LANGUAGE

Patients described the following as important when asked about important and meaningful experiences in the hospital:

#### 6.1.1 Religion and spirituality

##### **To care about others**

*... dit is vir my lekker om te weet dat ek kan omgee. Dit is 'n voorreg om om te gee en God gee vir ons nie almal daai voorreg nie. (P19:52)*

*...it is nice to know that I can care about others. It is a privilege to care about others and God does not give this privilege to all.*

##### **To share the word of God**

*I: Was there then anything ... that helped you; that was meaningful?*

*P: Yes ... because I have opportunity of sharing the word of God with some of the patients. I'm praying for them. (P14:374)*

*I: ... your best experience in hospital, what was that?*

*P: When I'm sharing the word of God. (P14:983)*

The weekly meditation group held by the pastor was also described as a good and meaningful experience, as previously mentioned. Good psychiatric care was described as involving a whole team, which should include a pastoral counsellor (P19:754). Pastoral care was the most important for some:

---

<sup>14</sup> I described the seventh model in Section 3.3.7.

*I: Wat sê jy dus was vir jou die mees belangrike belewenis in hierdie vyf weke?*

*P: Dat ek by ds. D kon uitkom. (P21:157)*

**Summary:** The most important experience was to see pastor D.

It was interesting how this patient described doctors being 'lower grade' or 'higher grade', but that this did not matter, since God helps them all. The seniority of the treating doctor was thus of no importance.

*I: Does it matter whether they are lower grade or higher grade?*

*P: No it's not... it's the same ... God help them, all of them, yes. (P3:357)*

It is important that a registrar should maintain openness towards a patient's religious beliefs and experiences, as this can further the therapeutic alliance:

*I: And he was interested in your religious beliefs and didn't just condemn those?*

*P: Yes, sir.*

*I: Ok. So that's why you would want to see him?*

*P: Yes, sir. (P14:1059)*

Religious or spiritual conflicts about how to understand their mental illness, as well as wondering about a connection between religious experiences and mental illness, is not uncommon:

*Want as ek nou vir jou sê die eerste keer toe ek in die weermag "bipolar" gekry het toe het ek my hart vir die Here gegee. Ek het tot bekering gekom in die weermag. Net daarna toe word ek siek. Nou in 2008 Julie, Loftus vir Jesus, toe het ek weer my hart vir die Here gegee, net daarna toe word ek siek. So dit lyk vir my of daar 'n verband is tussen my siekte en wanneer ek besluit om 'n heilige lewe te lewe, wanneer ek besluit ek wil nou vir Jesus volg. ... Dit lyk vir my daar is 'n sterk korrelasie tussen die twee. (P1:279)*

**Summary:** Twice after giving his heart to Jesus he became ill. It seems to him that there is a correlation between the two.

In my field notes, I wrote that the first participant, from whom the above-mentioned quote is, had described three such incidents where his relapses were linked to religious experiences, and he indicated a desire to understand this possible link. It seems that his treating team did not take this up.

The next two quotes, both from the same patient, express a similar struggle to understand a possible connection between his spiritual experiences or religious views and his mental illness:

*... now when I was admitted ..., I was admitted ... because I was in the church, they call themselves the 12 Apostles; so we were all night ... we were singing and praying until the morning and then in the morning, that's when I acted weird ... (P6:215)*

*I: How do you then explain this? What do you think is wrong?*

*P: I think the problem lies with my religion. I think the reason why I act weird and strange is because I believe that God has a calling for me and, because I'm not doing exactly accordingly that God has given me to be doing, then it becomes strange when I have dagga. (P6:201)*

The following patient even wondered whether God would punish her because of her seeking psychiatric help:

*P: Ja, dokter. En in my agterkop steek dit vas dokter, sal ek ooit hemel toe gaan as ek nou Weskoppies toe kom, is dit rêrig so, dat ek nie na Jesus toe sal gaan nie.*

*I: Asof die een nou die ander uitsluit.*

*P: Ja, dokter, want ek is 'n sterk gelowige mens en haar woorde ... dit steek vas. (P9:116)*

**Summary:** Will I go to heaven if I sought help in Weskoppies?

The experience of being in a closed ward was so terrible that it led this woman to despair and a questioning of her religious beliefs:

*Dis hel. Die lewe kan hel wees. Die lewe kan hel wees. Daar kom tye wanneer jy dit voel: my God is u nog daar, is u nog daar? (P19:376)*

*It is hell. Life can be hell. Life can be hell. At times you feel: God are you still there, are you still there?*

Some patients felt that not enough attention was given to the spiritual realm and that spiritual care should be incorporated more into their treatment. One patient felt that religious experiences are sometimes too easily labelled as mental illness, leading to patients hiding such experiences from doctors. Pastors should be involved, since they would have a better understanding of the patient and his or her experiences.

*P: I think the doctors are trained... I don't know but I think they... there are some things they lack...*

*I: Like what?*

*P: .... doctors, sometimes they don't believe in spiritual realm. And then psychologists I think they do believe in that spiritual realm exists. ...*

*I: So do you feel the spiritual, religious aspects are not addressed by the doctor?*

*P: I think so.*

*I: Is there anything else that lacks with the doctors?*

*P: With the doctors, they don't have enough time, I guess. (P5:429)*

*P: ... maar die Here maar die Here het tog 'n doel met ons. Maar God is net een gedeelte van 'n mens se terapie.*

*I: Is daar hier aandag gegee aan daai aspek? Spiritueel, godsdienstige aspekte.*

*P: Nee, glad nie. (P11:258)*

**Summary:** Religious aspects are a part of treatment, but this was not addressed during his present stay in the hospital.

*I: There's a lack of addressing the spiritual aspect?*

*P: Yes, yes, yes. (P14:903)*

The hospital has a chapel, but it is unfortunately not used often and is usually locked.

*P: ... ek het altyd die begeerte ... om kapel toe te gaan en gelukkig het hulle my toegelaat. En dit is vir my 'n baie diep ondervinding.*

*I: Staan die kapel altyd oop?*

*P: Ongelukkig nie, maar op sekere tye van die dag soos Donderdae byvoorbeeld word dit vir ander gelowe oopgestel, maar die res van die dag is dit gesluit ... (P11:270)*

**Summary:** The patient expressed the desire to visit the chapel, but it is unfortunately only open for a short time on Thursdays.

### **6.1.2 Culture and language**

Cultural differences were also mentioned as important, e.g. a male patient described the need for a male doctor, who also had to be knowledgeable about his culture and tradition.

*P: Yes, but now that one it's a bit difficult in the sense that she's a woman. ... Yes, she's a woman and ... the males... the ones that I'm with here ...the other patients here are the male ones, they know better. ...they understand where I come from because they are also Ndebele and men.... I would really love to see a male doctor and who can understand culture and tradition ... (P5:300)*

A female patient (P 12, field notes p. 13) again expressed the need for a female doctor, who she felt would understand her and her emotions much better than a male doctor.

Patients of different races expressed the importance of language. This is very understandable for a number of reasons. *Mother* tongue is what makes us feel close and

safe. Apart from this emotional value of language, certain patients are just not able to express themselves in another language. The following quote is from an elderly white female patient who struggled to communicate with her previous psychologist in English. This limited their interaction.

*Daar was nie soveel interaksie nie. Ek kon juig toe ek hoor ek het 'n Afrikaanse sielkundige. ...Die taal was belangrik. (P21:516)*

*There was not a lot of interaction. I was ecstatic when I heard I got a psychologist who is Afrikaans ...the language was important.*

The same holds true for this patient:

*Because I was talking with this other guy, he is from Mozambique, and he told me that he does see his doctor, but they are not talking what he wants to talk about with her. So... then I didn't understand because he didn't talk much, you know, so I just thought to myself that probably, maybe the reason is English, because sometimes we can't communicate very well with English with other people. (P5:337)*

For others, race and language was not an issue. The patient who was the most positive about his stay in WKH, patient six, was an elderly white man. He felt understood and supported by his black registrar and was especially grateful about the help received from him. For patient five, an elderly white woman, the most important person in the hospital was an African nursing sister.

## **6.2 FAMILY AND FRIENDS**

Patients have to cope with problems in the relationship with family members or loved ones and unfortunately at times also with their negative attitudes towards psychiatric illness and care:

*My familie, omdat ek wanneer ek manies is aggressief is, nie fisies nie, maar emosioneel aggressief is, so ... daar is familieledede wat gevoel het dat hulle sien nie meer kans nie. (P19:600)*

Because I become emotionally, not physically, aggressive when I am manic ...there are family members who feel that I am too much for them.

*Ek is een oomblik tevrede dan voel ek opstandig en dan asof ek kan uitskree en dan wil ek net huil, maar die meeste van die tyd wil ek net huil en my man verstaan nie wat gaan aan nie dokter. Hy ... ek is hier oor my gewig en oor depressie. Dan sê hy vir my dit lyk nie asof my gewig regkom nie, ek moet maar huis toe kom, verder vet word en vrek aan 'n hartaanval, en ek weet hy bedoel dit nie so kras nie, maar hy sê dit so kras vir my en hy glo nie aan sielkunde nie. (P9:56)*

**Summary:** The patient says that her husband shows no understanding. He says she is not getting better and should rather come home, become even fatter and die from a heart attack. She believes he does not mean what he says, but he does not believe in psychological help.

*I: So he could visit you, but he doesn't?*

*P: Ja.*

*I: Do you feel in a way rejected by him?*

*P: A lot more rejected, he even said he wants some space. So it's very difficult for me to understand after a relationship of eight years and now he just says he needs the space ...I'm even scared to say it's over, but it's just not working. (P18:146)*

### 6.3 SUMMARY OF CHAPTER 6

Family and friends, but also religion, spirituality, culture and language can play an important role in providing containment. These factors are important in the care and treatment of patients and can influence the therapeutic alliance, especially if the treating doctor does not understand the culture and cannot speak the language of the patient.

As I have shown here, family and or friends can have a very destabilising influence on the patient if they become critical and condemning. This could be due to having little understanding for psychiatric illnesses or as a consequence of their own inner conflicts.

I did not discuss the socio-economic and political situation, as well as the frame and treatment paradigm, since these aspects did not form part of the interviews. They are however important factors that I shall discuss in Chapter 9.

## 7 THE THERAPEUTIC RELATIONSHIP: A POSSIBILITY AWAITING REALISATION

In this chapter, I focus on the (possible) relationship between the patients and their registrars. I tried to minimise the repetition of quotes, but sometimes this is necessary to highlight an issue.

As an introduction herewith a quote to underline the problem around therapeutic relationships:

*I: ... would you say that there was a specific person, one person with whom you developed a meaningful interaction?*

*P: No, I wouldn't say that. (P4:29)*

### 7.1 IS A THERAPEUTIC RELATIONSHIP IMPORTANT TO PATIENTS AND WHY?

Such a relationship is undoubtedly of great importance to patients:

*I: How important are these weekly sessions with Dr T?*

*P: Very, very important. Because every single time I get to see her I see a bit of light. (P22:320)*

Dr. T was a very junior doctor at this stage, but still a source of hope for a patient; something very encouraging to all young registrars.

A patient wants to be personally known by the doctor, to have his unique individuality recognised and appreciated. They want to be more than a number. I already mentioned this in Chapter 6 and shall add only one further quote:

*Dat mens die idee kry dat jy nie nog 'n pasiënt of nog 'n nommer is nie en dat daar meer in jou belanggestel word as 'n individu, want op die ou end verskil ons maar almal. En dat ons nie almal oor dieselfde kam geskeer word nie, want elke persoon het sy unieke probleem. (P11:23)*

One should not get the idea that you are just another patient or only a number, but there should be an interest in you as an individual, because in the end we are all different. We should not all be treated in the same way, because each person has his unique problems.

The effect of not having such a therapeutic relationship was described as blocking personal growth and also harbouring the danger of not noticing signs of an impending relapse:

*I think it has blocked me from growing actually. It has not allowed me to grow or to even venture enough to other possibilities that are, like, could be underlying in my condition that I could sort out and be able to deal with, because there's a lot that is not being said, that I haven't spoken about.* (P7:61)

*I: Do you think that it is important to develop a type of relationship with your doctor? A therapeutic relationship?*

*P: I think it's very, very important.*

*I: How would you describe such a therapeutic, professional relationship?*

*P: I think most important thing your doctor must know you, because you will relapse and your doctor cannot believe that you have relapsed ... Dr C just said, no, go home, I can't admit you. He couldn't see that I've relapsed. ... If your doctor doesn't know you, it becomes very difficult for them to read that you have relapsed.* (P18:462)

*...veral as dit nou 'n nuwe dokter is dan vra hulle net jy weet hoe gaan dit, slaap jy goed, hoor jy stemme en sulke goed. ...daai dokters ... moet ten minste die pasiënt se geskiedenis 'n bietjie gaan naslaan, oplees dat hy kan sien, okay, die en daai het gebeur op daai en daai tyd en so en so, dat hy darem 'n geskiedenis het, maar nou kom jy daar. Die dokter ken jou geen kant af nie ... en dan, jy weet, dan help dit nie eintlik veel nie.* (P2:211)

**Summary:** New doctors only ask about symptoms; they should actually familiarise themselves with the history of the patient. If this is not the case, you already know that this is not really going to help.

## 7.2 FACTORS THAT INFLUENCE THE DEVELOPMENT OF A THERAPEUTIC RELATIONSHIP

I already mentioned some of these factors in Chapter 5. It is however important to list these factors again in this context, to help 'keep them in mind'. I shall again try to not duplicate quotes unnecessarily and have included different quotes on similar topics.

### 7.2.1 Aspects around time, frequency of being seen and boundaries

#### 7.2.1.1 **Seen soon after admission and informed about program**

*I got a bit frustrated and impatient, because I didn't get to see any doctor the first week. (P22:29)*

If a patient is not seen soon after admission, it can leave him or her to deal with many uncertainties, a difficult situation to bear with. The following quote is from a patient who fortunately knew an occupational therapist (R) who had previously worked in WKH; he could phone her to get reassurance that he would not be forgotten:

*Aanvanklik die eerste week het ek mos nou nie geweet wat aangaan nie, maar dit vat maar tyd vir dinge om in plek te kom. En gelukkig kon ek vir R bel en sy het vir my gesê, man, X weet van jou en dit is belangrik. En solank 'n ou weet hoe die opset werk dan is dit belangrik. (P11:102)*

Initially in the first week I did not know what was happening here, it takes time for things to fall into place. Fortunately I could phone R who told me that X (*the hospital OT*) knows about you; this is important. As long as one knows how the setup works; this is important.

Am I, the patient, being kept in mind? Have they forgotten me? What is going on, what will happen to me? These are questions one can expect a patient to mull over. Not knowing the setup and routine in a hospital and ward and not being informed soon after admission about the treating team and doctor can have a very negative effect on a patient. It is of great importance to meet and inform the patient about these aspects. The fact that “X knows about you” is reassuring.

### 7.2.1.2 Frequency of being seen

The frequency of seeing a patient is also of great importance. Due to a heavy workload in terms of patients and academic work, registrars usually see their patients only once a week. This is far from ideal, as commented on by the following patients:

*Dit vat baie lank. Jy weet dit is net een keer 'n week wat ek die dokter sien. So dan moet ek nou weer 'n week wag voor ek weer terugvoer kry en dan weer 'n week, en 'n week, en 'n week, en 'n week en voor jy jou oë uitvee is dit twee, drie maande. (P2:119)*

**Summary:** I see the doctor only once a week, then I have to wait one week for feedback, then another week and another week, and before you realise it two or three months have gone by.

Seeing an inpatient so infrequently will impair the development of a therapeutic relationship. Patients will then rather approach other team members, as mentioned earlier.

### 7.2.1.3 Addressing unrealistic expectations

Patients can have unrealistic expectations as expressed by the following patient who expected to be helped immediately. Such unrealistic expectations should be discussed with a patient and the underlying reasons elucidated. If such things are not addressed it can lead to a simmering negativity, poisoning the ward milieu. However, staff should also

keep in mind that patients often struggle to contain their problems and a more empathic answer than “Wait I’m busy” might alleviate many problems.

*P: Ja, want sy is altyd daar vir jou. Jy kan altyd met haar gaan praat oor enigiets. Sy sal nie vir jou sê soos die ander susters, “wait, I’m busy” nie. ... Hulle help jou nie dadelik nie. (P13:100)*

**Summary:** The patient said that this specific sister was always prepared to listen and to talk to her, whilst the other sisters would always say: “Wait, I’m busy”. They don’t help you immediately.

#### 7.2.1.4 Having time

The following patient stressed the importance of feeling welcome and not to be rushed, to have enough time. It is interesting that she also picked this up in the body language of the doctor.

*Ek voel baie goed oor haar, dokter, want sy laat voel jou welkom omdat sy anders lyk terwyl jy vir haar sien. Sy is nie haastig nie. Sy gee jou tyd om met jou te praat. (P4:147)*

I feel good about her, she makes me feel welcome, because she looks different whilst you are seeing her. She is not in a hurry. She has time to talk to you.

The next quote is interesting, since patients often want a diagnosis as quickly as possible. This patient, however, highlighted the importance of taking time to reach a diagnosis and, in certain situations, to start medication. Especially in private practice, the psychiatrist is under a lot of pressure to diagnose and start treatment as quickly as possible.

*Spandeer meer tyd, maak seker jy het die regte diagnose voor jy net medikasie verander, want die psigiater het die mag om medikasie te verander en in elk geval was dit ‘n absolute negatiewe stap, maar ja*

*weereens dankie dat ek hier by Weskoppies gekom het en dat ek die eerste week geen medikasie ontvang het nie en toe besef ek, maar ek voel dan nou baie beter. (P11:450)*

Take time to make sure that your diagnosis is the correct one before you change the medication, since the psychiatrist has the power to change the medication and it was a very negative decision, but I am again thankful that I was admitted to Weskoppies and that I didn't receive medication for the first week and then realized that I felt much better.

The following quote highlights another aspect of having time:<sup>15</sup>

*Yes, because some patients they have a lot of stories to tell, or they need to be asked certain questions and some people they don't... the time that is given probably is small, because the doctor needs to see maybe four or five patients before she leaves and that would be not enough for some people ... I think they... whatever the doctors are trained for, they're quick in doing things, like now as I'm talking to you right now, I'm open, I'm speaking to you and to me you sound like a psychologist, somebody who wants to know the... me, like, more. Unlike if I was talking with my doctor. With my doctor, she was going to be asking me questions that were relating to how I behave inside here and then this and that and then after... just besides that, I need to get more medication or I need to get less medication. And that is it, you know, so it wouldn't go beyond, you know, but with the psychologist, it would go beyond, it would be more. (P5:457)*

The time is too 'small' and doctors are 'quick'. His description of time as 'small' is very striking – it indicates another dimensional aspect of time, namely that having time creates a space, a space for being together.

---

<sup>15</sup> This quote was also discussed in Section 5.2.4.2.

### 7.2.1.5 Boundaries

Having a space implies having boundaries.

*There should be boundaries and limitations in that professional relationship. Even when I meet my doctor in the corridor, I should understand that he is rushing to get to other patients and not stand there and start talking to him about my problems, so it's about creating that space and know that I'm a doctor, I'm a patient. (P18:724)*

Boundaries are often seen as negative, but they create a safe space necessary for a close and meaningful interaction.

### 7.2.2 Short rotations

To be able to fit in all the different aspects of training, e.g. adult, child, adolescent and forensic psychiatry as well as neurology, the registrars rotate every four months. This means that a patient will have a new doctor every four months, definitely far from ideal as commented on by these patients.

*I: Het jy ooit met enige van die dokters wat jou oor die jare gesien het gevoel daar is 'n terapeutiese verhouding?*

*P: ... daar was van hulle, maar hulle is mos net elke keer vir ses maande en as jy, net wanneer jy nou rustig raak met hom dan kom daar 'n nuwe een. So dit is baie traumatiese vir baie pasiënte.*

*I: Die gedurige rotasie.*

*P: ... Dit is baie traumaties. (P19:650)*

**Summary:** The registrars change every six months (*now every four*); just when you get used to one, a new one comes. This is very traumatic for patients.

*I: Why Dr Y, what made her important?*

*P: Well she ... I think it's because she's been with me on this road ever since last year and one good thing about her ... I don't want to always repeat myself, because it seems like once you just get healed or in the healing process, you meet another doctor and you must start from scratch explaining your whole scenario. (P22:260)*

Dr Y is important, because she has journeyed with the patient.

### **7.2.3 Attitude**

The following nine aspects are indications of a caring attitude towards a patient:

#### **7.2.3.1 Being interested in the patient**

As mentioned in Chapter 6, patients are very observant of body language and sub-conscious signs of being disinterested and feeling bored. Proper care, treatment and rehabilitation starts with being interested in people and being empathic towards their suffering.

#### **7.2.3.2 Listening**

The ability to really listen is linked to the doctor's attitude towards a patient and is obviously of great importance:

*P: Ja daar was 'n persoonlike verhouding.*

*I: Wat is die verskil?*

*P: Hy het na jou geluister. (P13:664)*

**Summary:** There was a personal relationship, because he listened.

*...sy hoor wat ek sê. Daar is 'n verskil. Sy hoor wat ek sê maar sy luister nie... Sy hoor wat ek sê maar sy verstaan nie wat ek sê nie. (P13:484)*

*...she hears what I say. There is a difference. She hears what I say, but she does not listen. She hears what I say, but she does not understand what I say.*

Empathic understanding forms part of really listening.

### **7.2.3.3 Creating an atmosphere of acceptance, trust and safety**

The attitude of the doctor will also affect the development of trust and a feeling of safety.

*...as jy nie energie uitstraal wat 'n persoon veilig laat voel by jou nie, gaan jy 'n probleem skep vir die persoon. (P20:112)*

*...if you do not radiate energy that makes a person feel safe, you are going to create a problem for the person.*

*...confidentiality is very important. (P18:180)*

To confide comes from the Latin word *confidere*, which means 'to trust' (The Concise Oxford Dictionary 1982).

Trust, a feeling of safety and not feeling judged go hand in hand:

*Those people were looking at us, not in the way that we were sick people, they looked at us as we were normal people, then we were normal to them. And they experienced our normal... I mean, our being normal, because they didn't judge us and thought we were patients ...They respected us. (P5:149)*

This experience of being seen as a normal human being was described by the patient as an experience that really stood out. First of all we are human beings; and secondly patients.

However, how do you manage to let a patient feel safe?

*I: Hoe kry 'n dokter dit reg om iemand te laat veilig voel?*

*P: Oh, ek weet nie, dit voel asof ... kyk ek gesels nou openlik en openhartig en ek voel veilig. En ek weet nie hoe om dit te beskryf nie. (P20:114)*

*I: How does a doctor get someone to feel safe?*

*P: I don't know, it feels as if ... see, I talk now freely and frankly and I feel safe. And I don't know how to describe it.*

In Chapter 9, I reflect on the therapeutic relationship, which will determine whether a patient feels safe or not.

#### **7.2.3.4 Collaboration**

Collaboration between patient and doctor is nowadays regarded as very important, yet it does not always happen in practice:

*Yes, I think the hospital at the moment... could allow us enough time to decide on our own what to do, I think that would be significant to our becoming better. (P6:303)*

*Helpless ja. Helpless because the doctors are the ones who decide. (P18:84)*

*That's the most irritating feeling, because I don't know how long I'm gonna be kept here and what exactly must I do, because my doctor said if I behave well, if I take my medication, then ... I can be on a open ward and then they can easily discharge me ... So now I don't know ...Should I believe my doctor she is doing her best in making me strong, feel okay, or ... ? Somehow I'm feeling lost for something I don't really understand. (P6:324)*

The following quote demonstrates not only a lack of cooperation, but a high-handed arrogant approach:

*...maar daai newe-effekte ... was erg. En hoe meer ek dit vir daai Dr A verduidelik het, het sy net die houding gehad: man, ek is die dokter ...*  
(P11:314)

... Those side effects ... were bad, I explained it to Dr A, but her attitude was: I am the doctor.

#### **7.2.3.5 Giving positive feedback**

*Dit sal help dat 'n mens meer gemotiveerd bly as 'n mens positiewe terugvoer kan kry by iemand wat oor jou omgee...* (P8:19)

Positive feedback from someone who cares about you will help to keep a person motivated ...

#### **7.2.3.6 Being available and easy to reach**

Being available is another aspect noted as important by patients. Registrars have their mobile telephones, but are usually contacted through the hospital bleep system. They seldom provide their mobile numbers to patients – most are afraid that this will be abused by patients or their families.

#### **7.2.3.7 Keeping promises**

Keeping promises is an important aspect of interpersonal relations. As previously mentioned, if you make a promise, e.g. of seeing a patient on a certain day at a certain time, you have to keep to this.

### 7.2.3.8 Understanding the fears of the patient

It can change the whole atmosphere of a relationship if a patient feels understood in her fears.

*ECT - dit is hel op aarde (P19:456). Ek sal terapie probeer so ver as moontlik, (maar) ECT vermy... (P19:520)*

*ECT - that is hell on earth. I'll try therapy as far as possible, (but) avoid ECT...*

### 7.2.3.9 Overcoming resistances

The last characteristic I want to mention under this heading is the ability to overcome the resistance of the patient. Resistance, which I shall take up again in Chapter 9, is a feature of all patient–therapist interactions and refers to the patient's attempts to preserve the status quo and to avoid unpleasant feelings (Gabbard 2005). It indicates ambivalence about change and a fear to open up towards a psychiatrist or therapist (Gabbard 2010). In this quote, the patient tells us how this showed itself in the interaction with the registrar.

*I: Is there also something else in her personality, the way that she interacts with you?  
P: Very well, very nice, very calm and patient, she listens. She listened ... and a few times that I saw her I wasn't in the mood to see her, you know. I didn't want to speak about things that maybe bothered me. But the manner she approached the situation, made you want to speak about something, not necessarily the problem you know and then eventually the actual problem was discussed. (P22:272)*

The ability of this registrar to get the patient talking, to overcome the resistance, is linked to creating a feeling of trust and safety, a safe space, but there is probably more to it. Knowing this registrar and imagining myself in a discussion with her, I would think it has to do with a receptive, caring attitude, an attitude expressing interest in the person, which she is also able to express through her body language. It is the coming together of all the previous aspects mentioned; a special ability.

#### 7.2.4 The therapeutic relationship and the team

I mentioned that all patients are treated by a MDT. According to the different problems that patients present with, different team members will be involved. To address different aspects of care, more than one team member will usually be involved. This can however also create problems.

*I: Are you saying ... that (a) professional therapeutic relationship with one person is really extremely important?*

*P: Ja.*

*I: And that it wouldn't be possible if it was part of a team?*

*P: Ja.*

*I: So it would somehow be different or be diluted. It won't really be a good 1:1 therapeutic professional caring relationship?*

*P: Ja. (P18:606)*

Being treated within a team context does not and should not exclude a closer therapeutic relationship with one team member. This will depend on how the team handles this and the abilities of the carers as well as of the patient. A team could however be interfering with a team member's ability to function in his or her role. This is hinted at in the following quote:

*I: How do you feel about Dr Z?*

*P: He is a good doctor, but I've just realised that he can't make decisions by himself.*

*I: Oh, he has to go back to the team.*

*P: Ja. (P18:306)*

I shall discuss this again in Chapter 9.

### **7.2.5 Psycho-education**

The aim of psycho-education is traditionally seen as informing patients about their illness and helping them become experts in their own treatment, it is about empowering the patient (and where necessary his or her family) in order to improve the outcome and to prevent relapses.

*P: Yes, psycho-education as well. Ja, just for them to know what the person is suffering from.*

*I: Has that been done in your case, did they have such a session with your family?*

*P: No. (P18:708)*

*I: Did they not explain any of these side effects to you?*

*P: They didn't tell me anything about the side effects. I never spoke to them about side effects. (P17:380)*

Providing the patient with information not only empowers the patient, it also helps building a relationship.

### **7.2.6 Seeing the registrar with students present**

Medical students rotate through the various teams in the hospital, usually shadowing the registrar. These can be groups of between two and six students, who at times see the patients on their own to then discuss them with the registrar, or they will sit in during the consultations of the registrar and patient. I have already described how this can affect a patient in Section 5.4.3.

### 7.2.7 Other important factors

Language, culture and tradition were also mentioned by patients as very important in their interaction with doctors.<sup>16</sup> I discuss these factors and their importance in the literature review in Section 8.5.7 and in Section 9.3.3.2.

## 7.3 DOES A THERAPEUTIC RELATIONSHIP NEED A LONG TIME TO DEVELOP?

Relationships take time to develop. In De Saint-Exupéry's famous book, *The Little Prince* (1974), the fox teaches the little prince about this; he and the prince become acquainted over time. Yet, it is possible for a sense of safety and connectedness to be established immediately according to this patient (someone who had been hospitalised many times for a severe mental illness and had seen numerous registrars):

*P: Na 24 jaar het ek geleer dat slegs die dokters die beste in my uitgebring het wat ook 'n geestelike warmte gehad het. Maak nie saak wat dit was nie, maar wat empatie gehad het ...*

*I: So dit is nie eers noodwendig dat hulle jou oor 'n lang tydperk ken nie, of dat daar 'n langstaande professionele verhouding ontstaan nie, dit is net daai ingesteldheid.*

*P: Dis in daai oomblik. Dis in daai oomblik. 'n Mens het net 'n oomblik om 'n impak te maak en hulle sê 'the first impression lasts', so daai 'first impression' wat 'n dokter maak as hy 'n glimlag het of as hy ongeduldig is en as hy onhebbelik is ...Dis 'n ingesteldheid. Dit is nie net ingestel nie, dit is ... hoe sal ek dit stel? Dis 'n, dis 'n ... ek kan nie die woord nou kry nie, dis 'n wesenlikheid. Ja dis 'n wesenlikheid. (P19:800)*

**Summary:** Over a period of 24 years (*the time that she received psychiatric treatment*) she learned that only those doctors who had a spiritual warmth, who had empathy, brought out the best in her. Such an attitude is registered immediately; this attitude she calls an expression of the doctor's real and

---

<sup>16</sup> See Chapter 6.

essential being. This can immediately lead to a good therapeutic relationship; it is not something that always needs time to develop.

In the second interview, the patient repeated this:

*I: Nou is so 'n terapeutiese verhouding iets wat oor 'n lang tyd opgebou word? Waar dit 'n lang tyd verg, sê maar weke of maande, of is dit iets wat onmiddellik kan ontstaan en daar kan wees?*

*P: In 'n oomblik.*

*I: So binne 'n oomblik kan 'n goeie terapeutiese verhouding daar wees?*

*P: In 'n oomblik. (P20:94)*

**Summary:** According to her, a good therapeutic relationship can be established in the blink of an eye.

This is something to ponder on. However, one might counter that first impressions can be misleading and that this patient places too much emphasis on her initial feelings. As mentioned, she has however seen many doctors and had this to say about them:

*Dit was 'first impressions', so dit is daai energie wat 'n persoon uitstraal, uit sy gesig, uit sy liggaam, uit sy aura, uit sy persoonlikheid, iets wat hy sê. Oor die manier hoe hy groet, net byvoorbeeld om te groet as hy afkyk en kwaad is vir die vorige pasiënt en jy kom nou in ... (P20:56)*

It was first impressions; it is the energy that a person radiates, from his face, from his body, from his aura, from his personality, something that he says. It is the manner how he greets, for example whether he greets whilst looking down and still being angry with the previous patient and you come in ...

*... as jy nie energie uitstraal wat 'n persoon veilig laat voel by jou nie, gaan jy 'n probleem skep vir die persoon. Jy gaan 'n probleem skep. (P20:112)*

... if you don't radiate energy that lets a person feel safe being with you, you are going to create a problem for the person. You are going to create a problem.

## 7.4 WHAT IS POSSIBLE IN CHALLENGING CIRCUMSTANCES?

To establish a therapeutic relationship can be difficult for various reasons, for example being overworked, or close to burnout. Another reason is being afraid of the patient.

*P: ...want jy is mos nou psigoties, niemand wil jou naby hulle hê nie, jy is 'n bedreiging vir hulle, jy gaan hulle aanrand.*

*I: Almal is bang.*

*P: Almal is bang. (P20:184)*

*P: ...because you are psychotic, no one wants you near them, you are a threat to them, you are going to attack them.*

*I: Everyone is afraid.*

*P: Everyone is afraid.*

I want to end this however on a positive note, as did this patient. She, after so many years of treatment in WKH and many admissions to closed wards, as well as difficult experiences in seclusion, said that she would have been lost without this hospital every time she fell ill. She described the staff as having their faults as humans, but that she experienced more care and love than negativity (P20:208).

## 7.5 SUMMARY OF CHAPTER 7

Chapter 7 deals with the importance of the therapeutic relationship, starting with the question regarding why it is important and then addressing factors that influence the development of such a relationship.

Several patients mentioned how important such a relationship is. Reasons given are:

- It is a source of hope.
- Patients want to be personally known; they want to be more than just a number.
- Patients have a wish for personal growth. A therapeutic relationship can provide the potential for growth.

The situation in the medical field in South Africa, especially in mental health, is however very challenging, with a serious lack of resources and manpower. The question is how can a therapeutic alliance be developed in such circumstances? I found the comment of one patient that it can be established in the blink of an eye very interesting.

## **SECTION 3**

# **TOWARDS A MODEL OF THERAPEUTIC RELATIONSHIPS IN A PSYCHIATRIC HOSPITAL**

### **In this section:**

**Chapter 8: Literature review**

**Chapter 9: An analysis of the care and treatment offered at Weskoppies Psychiatric Hospital, leading to the development of a model and substantive theory of therapeutic relationships**

**Chapter 10: An analysis of the trustworthiness or 'goodness' of the study**

## 8 LITERATURE REVIEW

### A SUMMARY OF THE LITERATURE REVIEW

As an introduction, and to help with an overview, I start with a summary of the literature review.

- 8.1 The first section deals with comments about **'the ideal'** situation; first, what a hospital is supposed to be, and then different definitions of mental health.
- 8.2 Publications on aspects of **'the reality'** are introduced: difficult feelings and experiences for both patients and staff, and how these are handled, for example, by containment measures. Problems that have developed in the practice of nursing are also highlighted.

Most of the research on patient care and satisfaction was done by nursing personnel and not by psychiatrists. My impression is, that nursing personnel are focussed more than psychiatrists on doing *qualitative* research with patients.

- 8.3 Literature on **models of health care** is reviewed. The present focus in health care is still very much on biological treatment with the danger that the patient becomes an object of treatment. The bio-psycho-social and bio-psycho-social-spiritual models of care are introduced. These models practice according to a systems approach. A short introduction into systems theory is therefore also given.

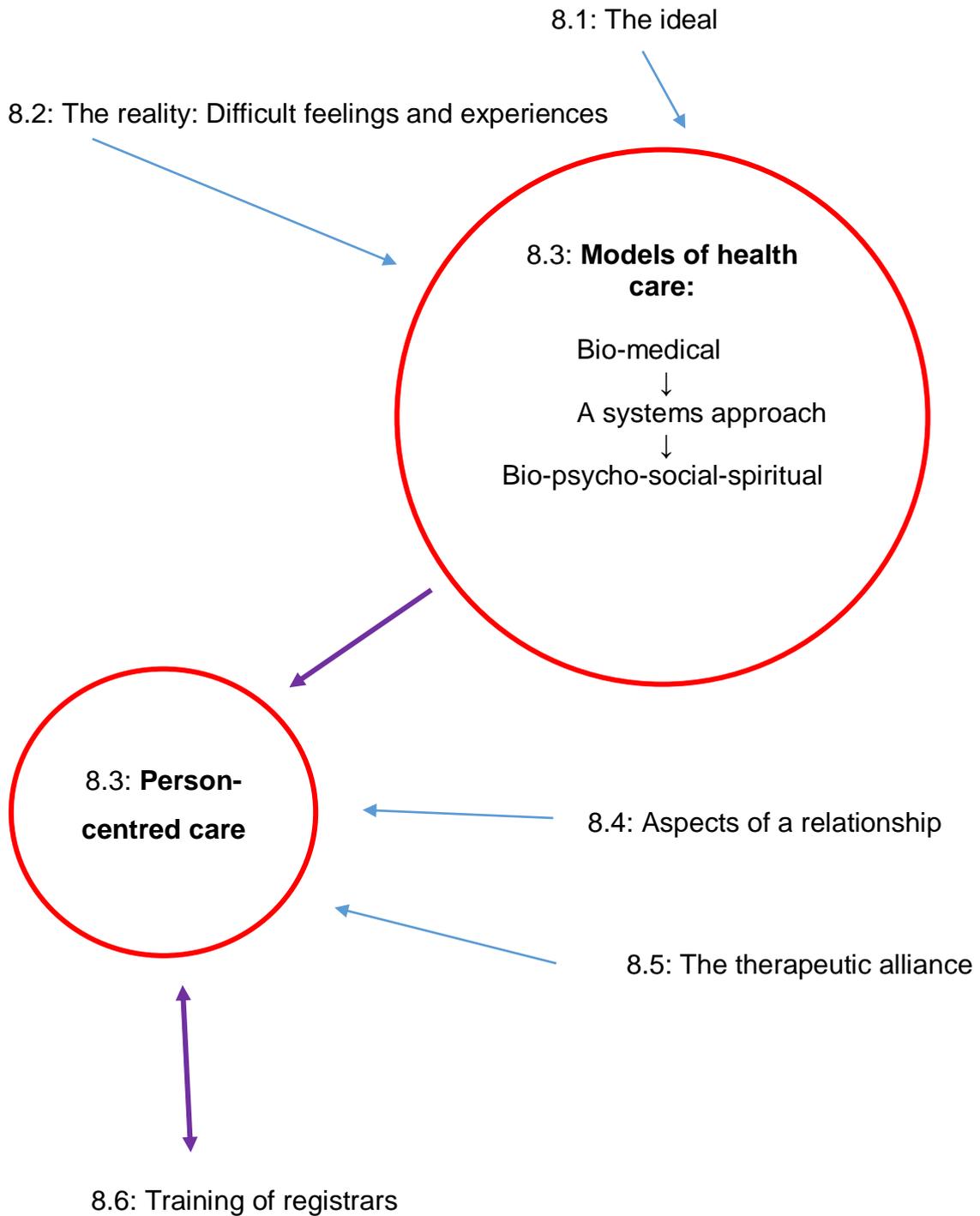
Research on patients' wishes and need for **person-centred care**, as well as differences between the bio-medical and person-centred approach to health care, are reviewed.

In thinking about models of health care, patients' experiences and opinions of good care are important. This is the next section. One important finding is that patients rate interpersonal aspects of care very high.

- 8.4 Following on this, literature on different **aspects of a relationship** is presented. Mirror neurons and attachment theory show how we are programmed for relationships. The ability to empathise is of great importance in all relationships, also the therapeutic relationship. Empathy, language, as well as verbal and non-verbal behaviour are discussed. The importance of the concepts of holding and containment in all therapeutic relationships are highlighted.
- 8.5 In this section, different aspects of the **therapeutic alliance** are focussed on. The literature is used to underline why this alliance matters. Amongst others, aspects of the effect of the social class and cultural differences are attended to.
- 8.6 Lastly, literature on several aspects of the **training of registrars** is reviewed. Topics that are not always discussed as part of training receive attention, such as mentoring needs, Balint groups, the registrar's personal characteristics as well as his or her mental health, and the teaching of psychoanalytic concepts and skills.

The different aspects that I discussed through reviewing the literature are all inter-related as depicted visually in the following drawing:

**Figure 8: The inter-relationship of the literature review**



## 8.1 MENTAL HEALTH CARE: THE IDEAL

### 8.1.1 What is a hospital supposed to be?

The physician Sweet (2012: 196), in writing about working in San Francisco's Laguna Honda Hospital, expresses the following thoughts about a hospital:

- The root of the word *hospital* is *hospitality*, and the root of *hospitality* is *hospes*, which can mean either 'guest' or 'host'. "The essence of hospitality - *hospes* - is that guest and host are identical, if not in the moment, then at some moment." Our current role is temporary: with time, a host becomes a guest and a guest becomes a host. Every doctor will at some stage become a patient.
- The second principle for her is that of *community*.

*Community* comes from the Latin *communio*, for which the *Oxford Latin Dictionary* gives two derivations. *Communio* as a verb comes from *munio* - wall - and means "to build a wall around". Therefore, a community is defined by the wall - symbolic or otherwise - around it. Everything inside the wall is the community, and everything outside the wall is not. ...But *communio* as a noun derives from *munis* - gift; so *communio* also means "those who share a gift in common". (Sweet 2012: 219)

You are a member of the community just by being inside the wall (interestingly a massive wall is at present being built around WKH) and by sharing something. In the ideal situation we are aware that we share a common identity, that of being *hospes* and of providing hospitality. However, what does it mean to share a gift? This reminds me of a patient who said in one of our interviews that it was a privilege for her to be there for other patients (P19:40; P19:52). She is sharing her humanity with others.

A hospital, although a place of help, is for most patients also a place of suffering and many difficult experiences. In the following sections, I discuss some of these difficult experiences.

First the question: What is mental health?

### 8.1.2 What is mental health?

“Too often, psychiatry has been preoccupied only with mental illness”, writes Vaillant (2003: 1373). Has this changed twelve years later? Mental illness can be reliably defined, but mental health seems to lie more in the domain of value judgment. It is more than the absence of symptoms. It is also not the antonym of mental illness. The antonym for physical illness is physical fitness. However, before an attempt can be made to define mental health, Vaillant advises that several cautionary steps are necessary, e.g. to note that average is not the same as healthy and to appreciate the ‘contamination by values’ and how mental health is seen differently in different cultures.

Vaillant (2003) contrasts six different empirical approaches to mental health:

- i. **Mental health as above normal:** A superior functioning in a wide range of activities, including social functioning. Combining Freud and Winnicott, one can say it is the ability to love, work and play.
- ii. **Mental health as positive psychology** (Peterson and Seligman 2004): Here the strengths or virtues of love, temperance, wisdom and knowledge, courage, justice and a sense of transcendence are emphasised.
- iii. **Mental health as maturity** (Menninger 1967): This refers to the capacity for love, the absence of stereotyped and unproductive patterns of problem solving, the realistic acceptance of one’s destiny, appropriate expectations and goals for oneself and the capacity for hope. Many studies illustrate the association of increasing mental health with maturity, probably in part mediated by the evolution of emotional and social intelligence. Erikson’s well known work on the life stages and development (Erikson 1950) can be conceptualised as expanding ripples in a pond. “Over time the adult social radius expands through the mastery of four tasks: identity versus identity confusion, intimacy versus isolation, generativity versus stagnation and integrity versus despair.” (Vaillant 2003: 1378).
- iv. **Mental health as social-emotional intelligence** (Goleman 1995): Accurate perception and modification of one’s own feelings, as well as being able to read the feelings of others from non-verbal clues (empathy). Skills in negotiating close relationships and the capacity to focus emotions on a desired goal.

- v. **Mental health as subjective well-being**, linked to self-care and optimism. Relationships are more important to subjective well-being than is money.
- vi. **Mental health as resilience**. Humans use three broad classes of coping mechanisms to overcome stressful situations: seeking social support, using cognitive strategies and lastly using involuntary coping mechanisms (defence mechanisms). Involuntary defence mechanisms can abolish impulses, relationships (e.g. in schizoid fantasy), reality or social learning (e.g. in acting out). Defence mechanisms can be classified from primitive, e.g. splitting, to mature mechanisms, e.g. humour. How these various coping mechanisms are used is a reflection of the resilience of the person.

In all the above-mentioned definitions of mental health, the issue of relationships features prominently. Mental health is intimately linked to the ability to form and sustain meaningful relationships. The longitudinal assessment of the mental functioning of the patient is important. Vaillant states that asking “How many years since age 21 have you spent employed?” is a much more useful question than “What is your present job?” In addition, “Tell me about your longest intimate relationship” is much more useful than “Are you married?” (Vaillant 2003: 1382).

## **8.2 MENTAL HEALTH CARE: THE REALITY**

Mental health care personnel and patients are faced with many difficulties. The reality is that these can become too much and can overwhelm any goodwill. Some of these difficult experiences in psychiatric hospitals are:

### **8.2.1 Difficult feelings and what to do with them**

“The psychiatric patient is alone. ... He feels lonely. ... He is a lonely man.” (Van den Berg 1972: 105). One could add: he feels depressed and sad, or anxious and fearful. He or she struggles with difficult, painful feelings and with controlling or regulating these feelings. At times, it is only a feeling of dread that is registered.

Emotions are responses to personally relevant and significant events and need to be regulated to allow flexibility in emotional response. Psychiatric patients tend to express their feelings in vague and ambivalent terms and often experience difficulty in identifying and managing emotional states (Del Piccolo et al. 2014). They may benefit from the aid of a sensitive clinician to help them recognise and make explicit their inner emotional state. Psychiatrists should be able to help patients name and express emotions and to suggest strategies to help regulate them. Helping patients to verbalise their feelings facilitates emotion regulation (Del Piccolo et al. 2014; Nyklicek, Vingerhoets and Zeelenberg 2011), predicts competent coping (Stewart et al. 2000; Zachariae et al. 2003), generates greater patient satisfaction associated with interpersonal care (Epstein et al. 2007) and increases collaboration (Little et al. 2001; Cruz and Pincus 2002).

A specific relationship between dispositional emotion regulation strategies and types of psychopathology has been described (Aldao, Nolen-Hoeksema and Schweizer 2010). In their study, they examined the relationships between six emotion-regulation strategies (acceptance, avoidance, problem solving, reappraisal, rumination and suppression) and symptoms of four psychopathologies (anxiety, depression, eating and substance-related disorders). Maladaptive strategies such as rumination, avoidance and suppression were associated with more psychopathology. They found a strong correlation especially between rumination and anxiety and depression.

Del Piccolo et al. (2012) studied how emotions emerge and are dealt with in first consultations in psychiatry. Patients' emotional expressions were described as either *cues* or *concerns* according to a system developed by an international group of researchers (Del Piccolo, Goss and Zimmerman 2005). *Concerns* are clear and unambiguous verbal expressions of emotions, e.g. "I am depressed"; *cues* are described as verbal and non-verbal hints suggesting an underlying emotion that lacks clarity, e.g. "I feel vulnerable". Cues lacking clarity were much more frequent than concerns and many cues were expressed without being considered explicitly on an emotional level. According to Del Piccolo et al. (2014) this may be explained by several factors, such as patients' emotional way of expressing themselves, psychiatrists' tendency to pay attention to those expressions which may be linked to symptoms and their treatment, and psychiatrists' expectations for patients to be explicit in their expressions of emotions.

Concerns or cues were then linked to the immediate response of psychiatrists. The process that allowed full expression of an emotion after a given cue or concern was strongly related to the verbal approach of the psychiatrist: in 90 per cent of emotions explicitly disclosed this happened once the patient had space to talk more about a given cue or concern (Del Piccolo et al. 2014). Active listening, acknowledgement and rephrasing of patient's statements, as well as empathy were crucial skills in helping patients to fully explore, express and understand their emotions. It is important that a prompt or clue given by the patient is immediately picked up by the psychiatrist and then further discussed and clarified. The approach taken by the psychiatrist is crucial in helping the patient to uncover specific feelings and in this way contributing to diagnosis and treatment. Female psychiatrists provided more 'space' to patients; that is they used silence, active invitations, etc. to seek further disclosure or new information. Male psychiatrist more commonly 'reduced space' by ignoring the cue or concern, by giving psychoeducation, or by suggesting possible solutions for the emotional aspect that had just been introduced.

Attention to emotions which are explicitly expressed or hinted at is important for the diagnostic process and for establishing a good therapeutic alliance. Being 'given space' is thus of central importance.

### **8.2.2 Difficult experiences around time**

Rhodes et al. (2004) studied communication in the emergency department of an urban, academic medical centre. Their findings are very interesting, although disturbing.

Of 62 medical history surveys and physical examinations, time spent on the introduction and medical history survey and physical examination averaged 7 minutes 31 seconds (range 1 to 20 minutes). Emergency medicine residents introduced themselves in only two thirds of encounters, rarely (8 per cent) indicating their training status. Despite physician tendency (63 per cent) to start with an open-ended question, only 20 per cent of patients completed their presenting complaint without interruption. Average time to interruption

(usually a closed question) was 12 seconds. Discharge instructions averaged 76 seconds (range 7 to 202 seconds). Information on diagnosis, expected course of illness, self-care and the use of medications, time-specified follow-up and symptoms that should prompt return to the ED were each discussed less than 65 per cent of the time. Only 16 per cent of patients were asked whether they had questions, and there were no instances in which the provider confirmed patient understanding of the information. (Rhodes et al. 2004: 262)

Patients, after being interrupted, rarely returned to complete their chief complaint.

Another study found that in the USA the average patient gets 22 seconds for his initial complaint before the doctor takes over (Marvel et al. 1999). Langewitz et al. (2002) comment that this style of communication is probably based on the assumption that the patient will mess up the consultation if allowed to talk as long as they wish to. They found, however, that the doctor does not risk being swamped if the patient is allowed to finish his or her list of complaints without being interrupted. In their study of 335 patients, mean spontaneous talking time of the patients was only 92 seconds. Their conclusion is that allowing two minutes will be sufficient for 80 per cent of patients.

Giving a patient time links to the previous topic of difficult feelings and allowing a patient 'space'.

### **8.2.3 Difficult experiences in closed wards: forced medication, seclusion and other measures of containment**

Patients on acute psychiatric wards can be aggressive and in some cases violent, making their treatment and supervision a very difficult task for the psychiatric staff involved in their care (Dack, Ross and Bowers 2012). Containment is thus a central concept in psychiatric wards. (A different perspective on what containment means is given in Section 8.7.7; here, in Section 8.2.3, it is used to describe measures to get an aggressive patient under control, or it can refer to close observation of a suicidal patient.)

Bowers et al. (2004) studied the effect of different containment methods on patients; they described eleven different containment measures that are internationally commonly employed to contain injurious behaviour on inpatient wards.

**Table 7: Description of containment measures**

	Containment	Definition
1.	PRN medication	Medication given at the nurses' discretion, in addition to regular doses, by any route and accepted voluntarily.
2.	Physical restraint	Physically holding the patient, preventing movement.
3.	Intermittent observation	An increased level of observation, of greater intensity than that which any patient generally receives, coupled with allocation of responsibility to an individual nurse or worker. Periodic checks at intervals.
4.	Seclusion	Isolated in a locked room.
5.	Time out	Patient asked to stay in room or area for a period of time, without the door being locked.
6.	Compulsory intramuscular medication	Intramuscular injection of sedating drugs given without consent.
7.	Psychiatric intensive care	Transfer to a specialist locked ward for disturbed patients.
8.	Mechanical restraint	The use of restraining straps, belts, or other equipment to restrict movement.
9.	Constant observation	An increased level of observation, of greater intensity than that which any patient generally receives, coupled with allocation of responsibility to an individual nurse or other worker. Constant: within eyesight or arms reach of the observing worker at all times.
10.	Net bed	Patient placed in a 'net bed' enclosed by locked nets, which he or she is unable to leave.
11.	Open area seclusion	Isolated in a locked area, accompanied by nurses.
	<i>prn: pro re nata</i>	<i>Pro re nata means that medication is given when necessary, although still to a prescribed schedule, but not according to a fixed routine.</i>

Dack et al. (2012) found that a high frequency of coerced intramuscular (IM) medication use was associated with negative attitudes of patients to nearly all types of containment. In wards where high levels of IM medication are used, even those patients who only witness this give lower approval ratings for a number of other containment measures. A high rate of coerced IM medication can thus have a very negative effect on all patients and it is important to first look for alternatives, e.g. oral medication. Explanations should be given to the patient involved where realistically possible. In a case where physical restraint of the patient can be avoided before and during administering of IM medication, the patient should be asked to accompany the staff to a quiet area of the ward to create as little disruption and distress as possible. In addition, all patients including bystanders should receive careful debriefing when an aggressive incident occurs, especially when it has led to a patient being contained using compulsory IM medication (Dack et al. 2012).

According to Jungfer et al. (2014: 94) “(t)he past 20 years in the UK have seen the reintroduction of door locking in acute psychiatry although, in the 1960s and 1970s, all non-forensic wards were continually open, with patients being kept safe through observation and engagement of the staff.” In 2010, the number of permanently closed wards had increased to 42 per cent (Bowers et al. 2010). Increased rates of aggressive incidents have been connected to a punitive or threatening atmosphere on an inpatient unit (Bowers et al. 2010). Being locked in can cause frustration and distress for patients (Haglund and Von Essen 2005). Personality problems and burnout of nursing staff can also lead to aggressive incidents on closed psychiatric wards; this might cause a more restricted attitude, provoking aggressive incidents and an increase in coercive measures (Decaire et al. 2006). Closed doors are also often used to replace the staff-patient contact, which again might lead to increased involuntary treatment and safety measures such as seclusion (Jungfer et al. 2014). There is even an on-going discussion whether closed ward settings themselves may increase the risks of dangerous incidents and absconding (Decaire et al. 2006).

Jungfer et al. (2014) designed a two-year longitudinal observational study to examine the effects of a change to a less restrictive policy on the frequency of seclusion and forced medication in a psychiatric hospital in Basel, Switzerland. After an extensive planning period, two previously closed wards were permanently opened in the second year of the

study. Two other remained permanently closed and two wards permanently open. In the whole hospital one-to-one care was increased in crisis situations, personnel was trained in de-escalation techniques, psychotherapeutic approaches were implemented and crisis management standardized.

The overall percentage of patients subjected to at least one seclusion across all wards decreased from 13.5 per cent in the first year to 10.6 per cent in the second year, with no significant changes in forced medication. On a ward-type level, there was a significant reduction of seclusion (from 15.9 per cent to 0.3 per cent) and forced medication (4.9 per cent to 0 per cent) on newly opened wards, without equivalent increase in seclusion on closed or open wards.

In summary, they found that the implementation of a less restrictive policy and opening of two previously closed wards was successful in reducing the percentage of patients who had to be subjected to seclusion and that the frequency of seclusion and forced medication on newly opened wards could be decreased significantly. They are of opinion that further efforts could result in a higher reduction of seclusion and forced medication, as for example the mean duration of seclusion remained high (18 – 24 hours) compared to a mean seclusion of about 20 minutes in the UK (here Jungfer et al. quote Steinert et al. 2010). Steinert et al. (2010) mention that mechanical restraints and seclusion are forbidden in some countries for ethical reasons and that in several European countries, as well as in the USA, there is increasing interest in initiatives to reduce seclusion and restraint. In the UK the average for physical restraint (mechanical restraint is not allowed in the UK) was 20 minutes. Seclusion is rarely used. (Jungfer et al. are thus not correct in how they quote Steinert et al.). Very interesting is that there is no use of seclusion or of any coercive methods in Iceland, instead they use 1:1 nursing (Steinert et al 2010).

This is however not an easy, straightforward topic. Ross, Bowers and Stewart (2012) report that locking of wards, as happened more and more in England, is associated with reduced absconding, but increased aggression and self-harm. They write that the proportion of patients absconding once or more has reduced from 15 per cent in 2001 to 10 per cent in 2010, as have absconding attempts (down from 27 per cent to 14 per cent), but increases are shown in aggression to objects (from 20 per cent to 28 per cent),

physical aggression to others (from 16 per cent to 21 per cent), self-harm (from 4 per cent to 11 per cent) and suicide attempts (3 per cent to 4 per cent).

One of the most important goals for psychiatric inpatient care is to produce a safe, therapeutic environment that is conducive to providing high-quality patient care (Bowers et al. 2013). Such an environment is associated with higher staff satisfaction and less burnout. Bowers et al. (2013) studied 136 acute psychiatric wards, including patients and staff, to understand how they differed in terms of conflict and containment. They define conflict as any patient action that threatens patient or staff safety, such as physical violence, verbal aggression, absconding, use of alcohol or illegal substances, self-harm and medication refusal. Containment refers to any method that psychiatric staff uses to prevent or manage the conflict event, such as seclusion, special observation, searching procedures, de-escalation, time-out, manual restraint, and enforced medication (Bowers 2006).

Bowers et al. (2013) found that the unique features of **high-conflict, high-containment** wards were their high numbers of unqualified and temporary staff, suggesting that mobilising large numbers of such workers does not produce a safer and less coercive ward.

It is also striking that although patient characteristics accounted for some of the differences between these wards and wards in the low-conflict, low-containment category, the structure of the ward and its activities ...also played a significant part, implying that efforts to increase order and organisation and program clarity could move some high-conflict, high-containment wards towards or into the low-conflict, low-containment category (Bowers et al 2013: 425).

(It is important to note that in the definition by Bowers et al. low containment means less use of coercive methods. This understanding of containment is different from the concept of containment I discuss in Section 8.7.7.)

In the **high-conflict, low-containment** wards the quality of the physical environment was worse and a greater proportion of staff were male (Bowers et al. 2013). These wards demonstrated a worrisome connection between poor physical environments, social deprivation and higher proportions of patients with schizophrenia and staff and patients from ethnic minority groups.

The existence of wards of this type shows that in the face of high levels of conflict, some wards managed to use low rates of containment. It is unlikely that this combination represented staff who were laissez-faire with patients or whose wards were out of control in some sense, for if either were the case, order and organisation and programme clarity would have been significantly lower than on other wards. Therefore, the findings suggest that such wards employed a low-confrontation, nonpunitive philosophy of care, an interpretation supported by the finding that they had excessively high rates of general rule breaking compared with other forms of conflict (Bowers et al. 2013: 426).

The third group, **low-conflict high-containment** wards, had a high number of patients, although they did not have significantly different numbers of staff per bed. The high levels of containment suggested that the staff responded to the higher patient numbers with a harsher regime of containment.

Wards with **low-conflict and low-containment** represent an ideal type to which other wards should aspire. These wards were the most coherent group in the study, yet they were also the least distinguishable from the other categories of wards in terms of patient characteristics and organisational features. Maintaining a workforce of permanent and qualified staff would appear to be a high priority, because it would facilitate improving the structure and clarity of the ward regime. This and the provision of decent physical environments are in the hands of management rather than the nurses on the wards, indicating that to some degree, low conflict and containment are outcomes of effective hospital management (Bowers et al. 2013).

The results show that even in the face of high rates of conflict, low levels of containment (including seclusion, coerced medication and manual restraint) can be achieved. They also showed that good structure and organisation on the ward have an impact and these matters are in the hands of nursing staff. Bower et al. (2013) describe it as curious that wards with high and low rates of containment varied more in use of intermittent observation (regular checks on patients) than of any other containment practice. They state that intermittent observation is one of the easiest forms of containment for staff to initiate and carry out and it is the least likely to be objected to by patients. It should therefore be used more.

Bowers et al. (2007) found an association between nurses' positive attitude to patients and the approval of containment methods that involved being in personal contact with patients. This "may be flowing out of a therapeutic concept of containment, one where the self is wielded in a relationship with the person needing to be contained in order to promote calm and safety" (Bowers et al. 2007: 354). There was however evidence that nursing students' attitudes to patients with personality problems deteriorated over time; this may indicate that an exposure to the widespread culture of negativity towards personality-disordered patients is damaging.

The use of seclusion is frequently harmful and traumatic to patients (Gaskin, Elsom and Happell 2007). It is of great importance to research and establish other ways of managing difficult patients. There is an increasing awareness that all types of containment should be reduced and that patient preference for certain containment measures should be followed as much as possible.

In Africa, more severe measures of containment are at times still used. Ndetei and Mbwayo (2010: 3) write about the situation they found in a hospital in Somalia: "Chaining as a physical restraint was a standard practice in the seclusion area and it was often demanded by the relatives who were the only people to nurse such patients". Ndetei observed a similar practice in Sudan, where three patients were chained to a hook on the concrete floor. Lack of knowledge about mental illness may lead to the mistreatment of such patients (Ndetei and Mbwayo 2010). They suggest that more research is needed to establish how common such unacceptable practices are.

#### **8.2.4 Difficult experiences around non-adherence or non-compliance**

The move in modern times from a patriarchal model to one of collaboration indicates that the importance of the relationship between doctor and patient is recognised. However, although patients are seen nowadays as partners in the planning of their treatment, at any given time only 54 per cent are said to comply with treatment (Kaplan and Sadock 2003). Especially in chronic illnesses such as tuberculosis, diabetes mellitus, hypertension, HIV-related illnesses, bipolar disorder and schizophrenia good compliance is required.

Chapman and Horne (2013) state that between 30 per cent and 50 per cent of medicines for long-term conditions are not taken as prescribed. Non-adherence is a global challenge for psychiatry and has been linked to suicide rates, all-cause mortality and hospitalisation for patients. It is obviously also a great financial loss.

Non-adherence is often a hidden problem. Stephenson et al. (2012) found that 72 per cent of patients with bipolar disorder or schizophrenia, whose prescription refill records indicated non-adherence, were rated as adherent by their physicians. Non-adherence is the product of a range of perceptual factors, such as patients' beliefs about their illness and treatment and practical factors such as resources influencing the motivation of patients and their ability to start and continue with treatment (Horne and Clatworthy 2010). A strong, trusting alliance between psychiatrists and patients may have a protective effect against non-adherence (Chapman and Horne 2013).

Sylvia et al. (2013) write that the effectiveness of pharmacotherapy in bipolar disorder is undermined by poor medication adherence, which typically ranges from 20 per cent to 60 per cent. Four factors have been identified as important in adherence:

- i. Patient-related, e.g. age, gender, ethnicity
- ii. Psychological: insight and attitude about medication
- iii. Medication-related, e.g. side effects
- iv. Social and environmental factors, e.g. the quality of the therapeutic alliance

Studies suggest that, apart from the therapeutic alliance, the treatment environment (e.g. access to care, cost of care, waiting times and pleasantness of staff) may affect medication adherence (Sylvia et al. 2013).

Sylvia et al.(2013) examined data from the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD). The 3037 participants' perception of the quality of the relationship with their psychiatrist and quality of psychopharmacological care were assessed by using the Helping Alliance Questionnaire and Care Satisfaction Questionnaire. They found that empathy and compassion shown by the psychiatrist, as well as perceived collaboration and access to the psychiatrist were positively associated with medication adherence. Timely appointments are important, as waiting times are associated with medication non-adherence. Collaboration with the patient, e.g. selecting treatment goals and interventions so that his or her feedback is incorporated in the treatment plan, is important. In contrast, discussion of medication risks/benefits and the degree to which the patient was motivated to solve his or her problem were not associated with adherence. This last finding is surprising and the researchers speculate that it might have to do with having had only one question on this topic. Their finding that patients' perception of the psychiatrist's knowledge was also not associated with adherence, is interesting.

Most of these factors were statistically significant regardless of the patient's present mood state and other factors associated with poor adherence, such as alcohol abuse.

### **8.2.5 Problems in the practice of nursing**

Mullen (2009) did a thorough literature review of the practice of nursing in acute inpatient settings. His references span the years 1996 to 2007 and he identifies the following problems:

- i. **Reduced patient interaction:** The amount of time nurses spent in meaningful face-to-face interactions has declined. Talking to patients seems to have been replaced by

observing patients (Bowers et al. 2005a; Bowles 2000; Higgins, Hurst and Wistow 1999; Hurst, Wistow and Higgins 1998).

- ii. **Observation culture:** A trend towards observing and monitoring patients has developed, rather than interacting and engaging with and understanding the patient (Barker and Cutcliffe 1999; Bowles 2000; Bowles et al. 2002). By observing the patient nurses inadvertently believe that they already have the necessary information to provide care.
- iii. **Defensive and reactive practice:** Time is spent reacting to situations, rather than being proactive in planning individualised nursing interventions. It seems that mental health nurses have become psychologically withdrawn from patient interactions (Bowles 2000; Fourie et al. 2005; Higgins et al. 1999). Mullen writes that this may be an attempt to protect oneself from burnout, or be the result of burnout itself.
- iv. **Focus on risk management and observation protocols:** Close observation protocols are a widely accepted method of managing those patients deemed to be at risk, although some have questioned the rationale and/or effectiveness of such protocols (Cleary et al 1999; Bertram and Stickley 2005; Bowers et al. 2005a; Bowles 2000; Bowles et al. 2002). Patients have also reported the experience of continuous observation as being degrading and humiliating (Bowles et al. 2002). A focus on risk as the primary problem potentially leads care away from the treatment of symptoms and the underlying condition. The emphasis should be on equipping the person with the skills to manage distress in order to overcome future situations where they may be at risk, rather than merely focusing on the risk itself.
- v. **Overemphasis on medication:** While medication is an important part of treatment, it would seem that it has become the default approach in situations where other interventions could be used, either alone or in conjunction with medication (Bowles 2000; O'Brien and Cole 2004).
- vi. **Custodial care:** Current practice has been criticised for being overly custodial; patients are largely supervised by nurses in a similar way that prisoners are watched by prison officers. Denial of patient requests has been linked with violence and the imposing of restrictions with absconding (Bertram and Stickley 2005; Bowers et al. 2005b; Bowles 2000; Cleary et al. 1999; Crichton 1998; Nijman et al. 1997). Not enough attention is given to respect and the use of choice to facilitate functional interactions and

behaviour. Setting limits should be balanced with being flexible. The goal is to provide opportunities for negotiating care.

- vii. **Lack of use of psychosocial interventions:** There is concern over the lack of routine use of psychosocial interventions within mental health services, including acute inpatient units (Gournay 1995; Sin and Scully 2008). One of the reasons for this situation has been the lack of skills and knowledge in the specific psychosocial interventions themselves (Baker 2000; Bowles 2000; Cleary et al. 1999; Gournay 1995; Gournay et al. 1998).

Acute inpatient units should provide treatments that work. Mental health nurses are at the forefront of this provision, but can feel powerless to break this cycle of reactive practice. Acute inpatient units are busy, chaotic and at times stressful places. This in itself is further argument for structured and planned approaches to practice (Mullen 2009).

### **8.2.6 Complaints by patients**

Difficult experiences can lead to complaints.

Haw, Collyer and Sugarman (2010) report that there is a paucity of literature concerning psychiatric inpatients' complaints; they therefore did a study in a 500-bed psychiatric hospital over a period of one year (2006). During this period, 383 complaints were made by 179 patients. Of the complaints, 349 were made by the patients themselves; the rest were made on their behalf by, amongst others, advocates and family. Two thirds of complaints were about staff or clinical matters and half of these concerned staff attitude or social behaviour. Common themes were alleged staff rudeness or insensitivity, verbally threatening or discriminating behaviour, ward rules infringing their comfort, and false accusations or documentations about the patient. Of the rest of the complaints, 12 per cent were about the quality and content of the treatment programme and 18 per cent about the behaviour and attitude of other patients.

Only a small proportion were considered serious. Complaints, however, tell us how the organisation or service is functioning in the eyes of the patients and whether needs and

wishes are met. They are a valuable source of learning for mental health services (Haw et al. 2010).

But, what do patients consider to be good care?

## **8.3 MODELS OF MENTAL HEALTH CARE**

### **8.3.1 The present dominant model or paradigm in medicine**

There has been a shift in psychiatry towards biological explanations and treatment of mental illness in the last two decades, as illustrated by the following:

- Research in biological and pharmacological approaches receives far more funding than psychosocial approaches and additionally more attention in terms of publications and practice (Soldani et al. 2005; Ghaemi 2006).
- Psychotherapy is fading from consciousness and practice in some developed countries (Weissman 2013). Interesting is that it is embraced in some developing countries. Weissman also refers to an editorial in the September 27, 2012, issue of Nature, which “(o)ut of character for a leading basic science journal” argued for the advancement of psychotherapy (Weissman 2013: 712). According to the editorial in Nature “it is a scandal” that money spent on psychotherapy research is tiny by comparison with the budget for research on pharmacotherapy (Nature 2012: 474).
- Mojtabai and Olfson (2008) found a significant decline in the provision of psychotherapy by psychiatrists in the United States in the years 1996 – 2005.
- Gabbard and Kay (2001) voice their concern about proposals in American psychiatry which explicitly call for a dramatic reduction in the provision of psychotherapy by psychiatrists. Under these proposals, they write, psychiatry would be reshaped in a biologically reductionistic direction.

An understanding of the biological aspects of mental illness is not a danger, but rather progression. The danger lies in an overemphasis of the biological, an avoidance of the personal and treatment directed towards alleviation of symptoms only. In his lecture to the

American Psychiatric Association in 1986 Reisser stated: “Most of these residents could and would have learned more about a stranger who was sitting next to them for an hour on an airplane trip than they had learned in these formal psychiatric interviews” (Reisser 1988: 151). He criticised an approach where the focus is on eliciting symptoms to then be able to make a diagnosis according to the DSM and not being curious about the patient as person. The patient becomes an object, a thing.

Romanyshyn (1989) discusses how our view and experience of the world has changed over the centuries and how, as an example, we have distanced ourselves from matter, from the body. This attitude towards the body is also shown in the invention of the body as corpse and the dissecting of this body. He illustrates this with two drawings. The first illustration presents a drawing from a 14<sup>th</sup> century text by the physician Vigevano (figure 9). “The earlier anatomist ... is looking at the body. More specifically he is looking at the face and, we might even say, at the closed eyes of this body.” (p. 122). This in itself is astonishing, writes Romanyshyn, because, and he quotes the Dutch psychiatrist Van den Berg, “here is the first incision in the history of Western anatomy” (Van den Berg 1978: 70). The anatomist / physician is not looking at the knife. Romanyshyn asks what we are to make of this attitude, and answers, that the dissection is apparently *not* the primary matter here. The primary matter is the *relationship*, which is portrayed here between the physician and the body, even with the dead body.

Figure 9: Guy de Parc, *Figure d'anatomie*, Chantilly, Musée de Condi (Romanyshyn 1989: 121)



The second illustration is a woodcut of the physician Andreas Vesalius, father of modern anatomy, in the year 1542 (figure 10). In the illustration, Vesalius is looking at the viewer, not the body. There isn't a bond between physician and body. The body is over there; it is

an object to be observed. The two illustrations are separated in period by about two hundred years, yet Vesalius is closer to us than he is to Vigevano, because we share his world.

**Figure 10: *Andreas Vesalius demonstrating a dissected arm*, woodcut by Johann Stephan von Calcar (Romanyshyn 1989: 120)**



According to the psychoanalyst Fromm, one of the ethical demands of our day is to overcome this concept of others as things. He takes a strong stance against the reductionistic approach in medicine: “Man is not a thing ... The knowledge of man is possible *only in the process of relating ourselves to him*” (Fromm 2004: 151-2). Michael Balint, founder of the well-known Balint groups for general practitioners (Balint 1985), voiced concern as early as 1930 that “the intimate relationship, which used to exist on a life-long basis between the patient and his doctor, has almost totally disappeared, replaced by quick superficial dealings” (Balint 2002: 13).

This was also noted by Engel more than thirty years ago. He wrote that the dominant model in medicine was the ‘biomedical’ model, but that the crippling flaw of this model was that it did not include the patient and his attributes as a person, as a human being (Engel 1980: 536). “Yet in the everyday work of the physician the prime object of study is a person, and many of the data necessary for hypothesis development and testing are gathered within the framework of *an on-going human relationship...*” (my italics). Engel therefore introduced the biopsychosocial model in 1977, based on a systems approach, to counter the preoccupation with the body and with disease and the corresponding neglect of the patient as person.

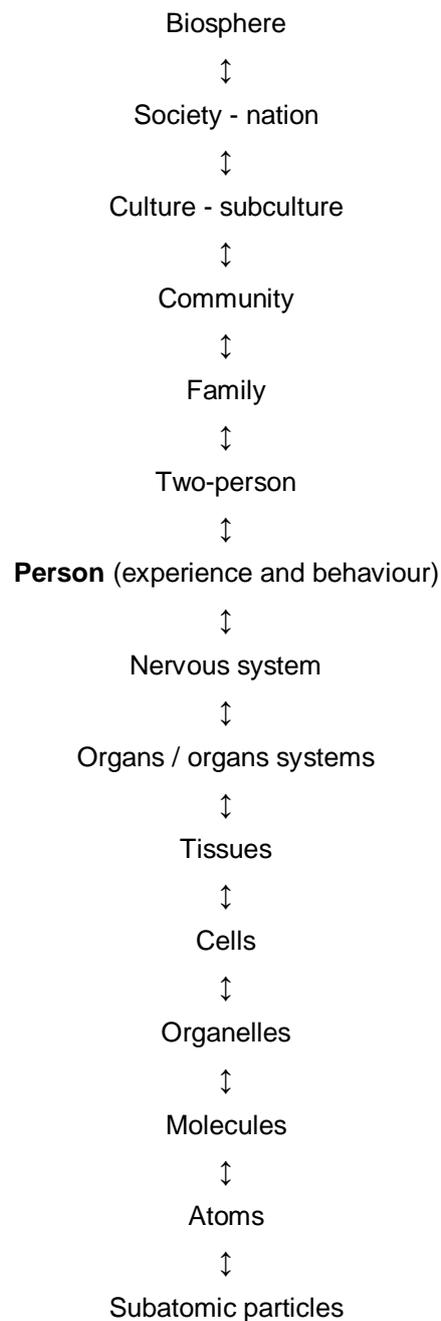
For Engel, this does not mean to cloak a biomedical model with a humane touch. It includes the humane, but goes deeper. He uses the case of Mr Glover (a pseudonym), who suffered a myocardial infarction, as an example. In the parsimonious approach of the biomedical model, the ideal would be to find the simplest explanation as quickly as possible, preferably the diagnosis of a single disease, in this case an acute myocardial infarction, which would suffice to define the doctor’s job.

In his biopsychosocial approach the problem is seen at different levels; first the levels of cell, tissue, organ and system, then on the person-level. Here the problem is how the patient as person handles the threatening situation, how his psychological make-up and resultant actions impose an even greater burden on his already overburdened heart. Then however, on the next level, that of a two-person system, people close to him help contribute to a psychological stabilisation and a lessening of the burden. A few days later, when events were reconstructed, the suggestion was that extracardiac, neurogenic

influences on the *person* and *two-person* level played a major role in the triggering of the infarction. All the different levels have to be addressed in the handling and treatment of the patient. Central for Engel is the relationship of the physician to the patient as person, an aspect neglected in the biomedical model.

**Figure 11: Hierarchy of natural systems (Engel 1980: 537)**

**SYSTEMS HIERARCHY (LEVELS OF ORGANISATION)**



Engel writes that consideration of the hierarchy as a continuum also reveals that each system is at the same time a component of a higher system. “In the continuity of natural systems every unit is at the very same time both a whole and a part” (p. 537).

Furthermore, about the person being central:

In scientific work, the investigator generally is obliged to select one system level on which to concentrate, or at least at which to begin, his efforts. For the physician that system level is always *person*, i.e., a patient (Engel 1980: 537).

Another development in the last two decades has been that spirituality and religion have received more attention and are increasingly recognised as being of importance in the understanding of psychiatric and psychological disorders and in the clinical assessment and treatment of patients (Curlin et al. 2007; Eichelman 2007; Blazer 2012; Vieten et al. 2013; Janse van Rensburg et al. 2014a). A biopsychosocial-spiritual model is proposed. Janse van Rensburg writes that it has become important to establish how, within accepted boundaries, spirituality should be incorporated into psychiatric practice and has proposed a model how this might be done in the South African context (Janse van Rensburg et al. 2014a).

In spite of these developments, my impression is that a reductionistic bio-medical model is still practised in psychiatry. In ward conferences and other presentations, a holistic model is presented, but when it comes to the practical aspects of treatment, psychiatrists focus on the biological part of treatment; it is as if they are not really *able* to do it differently. They are then mostly seen as “impersonal and unreflective pill-pusher(s)” (Mintz 2013: 753).

### **8.3.2 A systems approach**

According to Sluzki (2007), Engel’s 1977 biopsychosocial model was hailed as an alternative approach to a reductionistic biomedical view and a plea for a systemic view of

practice. Sluzki goes on to quote the Nobel Prize winner Kandel and summarises the principles of Kandel's 1998 paper into three key tenets:

- i. The mind is biologically based.
- ii. Genes determine the biological base.
- iii. Experience - both learning and psychotherapy - structurally alters this genetic expression.

Engel's and Kandel's propositions are then reformulated by Sluzki (2007) as follows:

- i. Mental processes, the neurobiological stratum and the social/relational world operate as a system (or are a system), and as such reciprocally influence each other. The social/relational world is inclusive of several systemically related layers: the family, the personal social network, the community, the socio-economic environment, the ecological niche and so on. These factors influence each other and can also buffer changes, e.g. the family can be a buffer against the impact of social changes.
- ii. Mental processes, the neurobiological stratum and the social/relational world coevolve.
- iii. Changes in the social world unavoidably affect both the psychic world (the mental processes) and the somatic stratum, directly through the neuro-endocrine subsystem and indirectly through mental processes. Stability and change in the social world affect the emotional and cognitive processes of the individual.
- iv. Changes in the neurobiological system unavoidably affect both the mental processes and the immediate social world.
- v. Changes in the mental processes translate into changes both in the somatic stratum and in the immediate social milieu.
- vi. All these processes are affected by, and affect, the genetically programmed constraints.
- vii. The set (social milieu ↔ mental processes ↔ neurobiological processes) is sensitive to changes facilitated by psychotherapy.

As agents of change, our actions may target one level of the system, but will also be located at the interface between systemic levels. The view of the world is one of an

unstable system. Sluzki thus emphasises a systemic view in which many factors influence each other and may either destabilise the system, or buffer the impact of changes.

### **A short introduction into systems theory**

The assumptions of linear cause/effect thinking, reductionism and determinism served Western scientific thinking well for generations and will continue to do so for many more. Part of that tradition is a belief in individualism. Systems theory, however, directs our attention away from the individual and individual problems in isolation towards relationships (Becvar and Becvar 1996; Winek 2010).

Instead of linear causality, systems theory emphasises reciprocity and shared responsibility. The question is not why something has happened, but rather the question of what is going on. The perspective is holistic, with the focus on the processes and context that give meaning to events, instead on individuals or events in isolation (Becvar and Becvar 1996). Processes emerge from the interaction of the parts and are thus more than just a characteristic of individual parts. Consideration of an aspect of a situation will only allow partial understanding; to get a complete picture one has to consider all parts and the relationship interaction or interaction patterns from which certain processes emerge (Eksteen quoted in Mouton 2001: 190).

The systemic concepts of equifinality and equipotentiality are contrary to a linear view of the world. The notion of equifinality states that there are an infinite number of ways to reach a certain position, e.g. many factors can contribute to someone developing a depressive disorder. Equipotentiality means that any situation or state can have an infinite number of possible future outcomes (Winek 2010).

Becvar and Becvar (1996) use the concepts of cybernetics and general systems theory as synonyms. The term 'cybernetics' originates from the field of engineering; it is a word taken from the Greek meaning 'steersman'. Systems theory was however, the catch phrase that caught on, stemming from the book *General Systems Theory* (1968) by the philosopher and biologist Von Bertalanffy (Becvar and Becvar 1996).

For Winek (2010), cybernetics form part of systems theory. Key terms in systems theory, according to him, are:

- i. **Cybernetics**, which is the core of systemic thinking in family therapy, refers to a control mechanism. “This new science focused on the similarities between control of inanimate machines and control of living systems. This was achieved by looking how communication and feedback combine to control a system” (Winek 2010: 12). In family therapy, for example, a cybernetics approach will look not at what is said, but at the mutual pattern that exists in the communication between the couple and how this is used to maintain control of the other or the situation.
- ii. **Structure** refers to the relatively enduring framework of a system. It is the sum total of the interrelationships among elements of a system and refers to those people or elements belonging to the system and the boundary between the system and its environment. The structure will vary based on the point of view of the observer. A family system, for example, will be very different to the youngest child, who feels that her siblings pick on her, than it is to her older brother.
- iii. **Boundaries** separate a system’s structure from its environment. Boundaries are not always clear or consistent. “The boundary is the container for a system” (Winek 2010: 14).
- iv. **Process** is the observable and dynamic interaction of the parts of a system. Everything that happens within relationships in the system is process. Process and structure are interrelated. A change in structure will cause a change in process. The opposite is also true: a change in process can result in a change in structure, but in most instances, a new process needs to be established for some time before it will result in a change in structure; it has to become a pattern.
- v. **Communication** refers to the exchange of information among components of a system on a verbal and non-verbal or action level. Non-verbal communication is primarily governed by our unconscious mind and is a more basic mode of communication. We are more likely to communicate a non-truth verbally, but our nonverbal behaviour often tells the truth. When verbal and nonverbal communication delivers the same message, the communication is said to be congruent.
- vi. **Metacommunication** refers to communication about communication. It involves a discussion about the process of communication and serves to control a system.

- vii. **Feedback** describes the aspect of the system that is recursive or self-correcting and whereby a system regulates its functioning.

In the field of family therapy, a shift occurred from a modern or first-order epistemological perspective to a postmodern or second-order epistemological perspective towards the end of the last century. Central to the modern era in science was its emphasis on structure and an analysis of how a structure functions. Pathological, dysfunctional structures were differentiated from functional or healthy structures. “The first-order perspective focused on pathology that was seen as occurring in problems in the structure of the family” (Winek 2010: 26). It emphasised pathology rather than health. Defining what is normal is however difficult.

In the postmodern view that evolved, reality was no longer seen as something absolute, but that it comes about as a result of shared subjective experience. The analysis shifted to that of the interaction of language and experience. Narratives told by people became important. “Stories are important factors that shape how reality is experienced” (Winek 2010: 27). Therapy is seen as a collaborative undertaking; change results from the therapist-client interaction. The cybernetics metaphor was also criticised as being too mechanical and that it did not account for the unpredictability and free will of humans.

Winek writes that an additional challenge to the modern, linear epistemology that dominated scientific thinking and the medical field occurred in 1977, when Engel disputed the traditional reductionistic approach in medicine with his model of a biopsychosocial approach. “Engel looked to general systems theory as a possible solution for the crisis he saw in biomedicine. By considering different levels of the processes above the cellular level, one is able to develop a more holistic approach to medicine and ultimately psychiatry” (Winek 2010: 30).

### **8.3.3 The wish and need for person-centred care**

Mental health problems are on the increase, as illustrated by the statement of the World Health Organization (2012) that depression is the leading cause of disability worldwide.

The mainstay of treatment for psychiatric illness is medication and psychotherapy. Despite advances in psychiatry, for example the development of newer antidepressants, there is, however, no evidence that treatment outcomes are better than they were a quarter of a century ago (Mintz and Flynn 2012). In one of the biggest trials ever on the efficacy of antidepressants, the finding was that only 30 per cent of patients reached remission when treated with a very commonly prescribed antidepressant (Trivedi et al. 2006). Most bipolar patients cannot be maintained on drug treatment alone (Miklowitz 2008). Yet biologically reductionistic approaches dominate psychiatric care and the trend is to treat a disorder rather than a whole person (Mintz and Flynn 2012).

Psychiatry can never be seen as only a biological discipline (Wallace 1983). A human being is never only a constellation of synapses, but a person in connection with others and a person through others. Interpersonal relations are, according to Wallace, the only real thing in psychiatry. The following stories or statements illustrate this need for a relationship, the need for another person who is willing to listen and share the patient's story, suffering and loneliness.

A despondent physician who had just been interviewed by a psychiatrist said: "I don't think he heard me ... Depression may be the disease, but it is not the problem. The problem is my life. .... It's falling apart. My marriage. My relationship with my kids. My confidence in my research. My sense of purpose. My dreams. Is this depression? ... I want this depression treated, all right. There is something more I want, however. I want to tell this story, my story. I want someone trained to hear me. I thought that was what psychiatrists did" (Josephson and Peteet 2007: 196).

A patient said about the staff of an inpatient unit: "When they see me, when they seriously meet and relate to me, then I exist as a person" (Johansson and Eklund 2003: 343).

Loneliness is the nucleus of psychiatry, and psychopathology is the science of loneliness according to the Dutch psychiatrist Van den Berg (1972). He

goes as far as to say that, with the exception of some organic disorders, if loneliness did not exist, psychiatric illness would not occur either.

One of the worst aspects of schizophrenia is the profound isolation – the constant awareness that you’re different, some sort of alien, not really human (Saks 2007: 193).

Unfortunately, even professionals at times do not understand this, as illustrated by the following excerpt from Saks (2007: 212). Saks, Associate Dean and Professor of Law, Psychology and Psychiatry and the Behavioural Sciences at the University of Southern California, was diagnosed with schizophrenia many years back. She spoke to a mental health professional, then on the Yale faculty, who did not know her history:

“Wouldn’t you agree that being restrained is incredibly degrading?” I asked.

“Not to mention painful. And frightening.”

The professor looked at me in a knowing way. “You don’t really understand,” he said kindly. “These people are different from you and me. It doesn’t affect them the way it affects us.”

Increased specialisation has led to a fragmentation and compartmentalisation of service with a focus on symptoms and illness and not on the person (Böhmer in press). There is an awareness of this one-sided approach and The World Psychiatric Association (WPA) has for example launched an initiative of Psychiatry for the Person, emphasising the need for a holistic and person-centred approach (Mezzich 2010; Mezzich 2011). The goal is to place the *whole person*, rather than the disease, at the centre of mental health care (Mezzich et al. 2010). The ‘Institutional Program of Psychiatry for the Person’, established by the WPA in 2005, aimed at promoting psychiatry with the following characteristics (Mezzich et al. 2010; Mezzich, Christodoulou and Fulford 2011; Miles and Mezzich 2011):

- **Of the person:** The totality of the person’s health is addressed, including both the ill and the positive aspects.
- **By the person:** Psychiatrists and other health professionals extend themselves as total human beings and not merely as technicians.

- **For the person:** The fulfilment of the person's health aspirations and life project is promoted, the focus is not merely on management of disease.
- **With the person:** Working respectfully and in an empowering manner.

Person-centred psychiatry is contingent on the quality of the therapeutic relationship and an integrative approach to the mind, the body and the spirit. It is an approach combining science with concern for the dignity, autonomy, values and responsibility of *every* person involved – including patient, family members *and* physician. The whole person is treated, since it is impossible for the part to be well if the whole is not well (Mezzich et al. 2010). This fits into the World Health Organisation's definition of health as a complete state of physical, emotional and social well-being, and not merely the absence of disease (Mezzich 2005; Mezzich 2010). There is no health without mental health.

In a person-centred approach, diagnosis can be seen as an attempt to understand what goes on in the body and mind of the patient (Mezzich et al. 2010). The patient's life context has to be assessed since health involves the ability to pursue one's goals in life. An understanding of an illness involves understanding of the interactive aspects of a bio-psychosocial-spiritual framework, the interaction between patient and others, patient and culture, as well as environment (Böhmer in press).

**Table 8: Differences between the bio-medical and person-centred model of medicine**

<b>Bio-medical model</b>	<b>Person-centred model</b>
Focus on symptoms, the patient as carrier of illness	Focus on the person; the patient as person comes first; value and dignity of patient emphasised
Diagnosis of an illness	Diagnosis of an illness in the context of the life history and current illness narrative; illness experience explored
Relationship between physician and patient not important	Patient-physician relationship central to treatment
Person of physician not important; impersonal provider of care	Person of physician very important
Non-verbal communication not seen as important	Non-verbal communication very important

Treating illness	Treating illness, but also promoting prevention and emphasising positive health
Patient not recognized as an 'expert' and partner	Patient competence and expertise in his/her illness recognised
Knowledge of people not important	Knowledge of people important

Saks (2007) has this to say about her treatment and especially about her psychoanalytic treatment:

Medication has no doubt played a central role in helping me manage my psychosis, but what has allowed me to see the meaning in my struggles – to make sense of everything that has happened ...and to mobilize what strengths I may possess into a rich and productive life – is talk therapy. There may be a substitute ...but I don't know what that substitute might be. It is at heart of things a *relationship*, and for me it has been the key to every other relationship I hold precious (Saks 2007: 331).

And about her experiences of involuntary care:

I write because I know what it's like to be psychotic. And I know, better than most, how the law treats mental patients, the degradation of being tied to a bed against your will and force-fed medication you didn't ask for and do not understand. I want to see that change, and now I actively write and speak out about the crying need for that change. I want to bring hope to those who suffer from schizophrenia, and understanding to those who do not (Saks 2007: 331–332).

And about further treatment:

My last two hospitalizations left me with “very poor” and “grave” prognosis. Those are the prognosis I would have lived out had I not had very skilled,

very dedicated talk therapists – psychoanalysts – by my side. ...I have a major mental illness. ...I will always need to be on antipsychotic medication and talk therapy. ...the humanity we all share is more important than the mental illness we may not....My good fortune is not that I've recovered from mental illness. I have not, nor will I ever. My good fortune lies in having found my life (Saks 2007: 334–336).

#### **8.3.4 Research on patients' experiences and their opinions about what constitutes good care**

In the last decades there is an increasing interest in the patient's perspective of psychiatric care and patient satisfaction is considered an important measure of the quality of psychiatric treatment (Johansson and Eklund 2003; Røssberg et al. 2006). Other fields of medicine also emphasise patients' satisfaction, for example an editorial in the British Journal of Anaesthesia focussed on the patient's experience of healthcare as very important (Heidegger 2008).

Patient satisfaction might even be linked to outcome: a study of 34 patients suffering from schizophrenia found that patients who were dissatisfied with their treatment had significantly longer duration of subsequent hospitalisations (Priebe and Gruyters 1995). High levels of apparent satisfaction are routinely found in surveys of patients using mental health services, yet non-compliance with treatment continues to be a major problem (Johansson and Eklund 2003). Commenting on these confusing findings, Johansson and Eklund (2003) write that most studies concerning satisfaction have used questionnaires to collect data, and that it is unclear what exactly different questionnaires measure.

Quantitative research can provide valuable information about patient satisfaction. Such studies have however, their limitations and most surveys have been described as conceptually flawed and methodologically weak (Coulter and Cleary 2001). How questions are phrased can for example lead to different conclusions. In their quantitative study, Barker et al. (1996) found that positive statements yielded high levels of satisfaction and many negative statements yielded low levels of satisfaction. They concluded that patients

tended to passively agree with statements. Another problem is that patients are reluctant to express critical comments about the care they have received in hospitals in surveys such as questionnaires (Fitzpatrick 2002). Almost 90 per cent of 2249 respondents involved in one study indicated that they were satisfied with their inpatient care, yet at the same time many of these patients indicated problems with the very same care (Bruster et al. 2002). A study of 5150 randomly chosen NHS patients in the UK showed a satisfaction rating of over 89 per cent, although problems were reported when patients were asked about specific aspects of their care (Bruster et al. 2002). Such positive results can hide existing problems.

Patient satisfaction is therefore not easy to measure or understand. For example, a study on satisfaction with postoperative pain management showed that of 76 per cent of patients who reported moderate to severe pain, only 8 per cent were dissatisfied with their care (Svensson, Sjostrom and Haljamae 2001). According to Barker and Orrell (1999), there is confusion about what is thought to be constituents of satisfaction and this leads to a trend to increase the size of questionnaires in the quest to measure anything that might be important. This may jeopardise the validity of measurements.

Johansson and Eklund (2003) recommend more in-depth qualitative studies, since it is important to know what brings about and what creates high or low satisfaction. In their qualitative study, patients equated good psychiatric care with the existence and quality of a helping relationship. Patients wanted to feel respected and to be understood. Johansson and Eklund are of the opinion that psychiatric research on the therapeutic relationship is neglected and that psychotherapeutic principles should be incorporated in all provider-patient relationships.

According to several researchers, little is known about what actually happens to patients during their stay on acute psychiatric wards (Muijen 1999; Quirk and Lelliott 2001; Lloyd-Evans et al. 2010). Patients have, however, complained about not having enough time with staff (Gilbert, Rose and Slade 2008). Lloyd-Evans et al. (2010) did a study on the relationship of care received to patient satisfaction and reached the conclusion that patient-staff contact is an important determinant of patient satisfaction; increasing it should be a priority for all acute in-patient services.

Patients are seldom asked to provide first-person accounts of their lived experience on inpatient units. Thomas et al. (2002: 99) state that “(n)ot since Goffman’s *Asylums* (1961) has there been an in-depth examination of the phenomenal world of the hospitalised psychiatric patient”. Goffman, a sociologist, went undercover and gave an insider view of the life and realities of being a patient in a mental institution (Goffman 1961). Suibhne (2011) writes that “*Asylums* is, above all, a text that humanises a dehumanised group of people” (Suibhne 2011: 1) and that Goffman’s critique is directed towards the overall relationship structure within the asylum, “a model based on expertise and of unrelievedly unequal power relations...” (Suibhne 2011: 2).

According to Thomas et al. (2002), extant literature focuses on the staff’s role in creating the therapeutic milieu rather than the patient’s perception of it. They also write that it is not known whether patients derive more benefit from the structured components of the milieu (for example staff-led meetings, therapy groups and psycho-educational classes) or from spontaneous occurring interpersonal interactions. There is a lack of qualitative studies addressing these issues (Johansson and Eklund 2003; Thomas et al. 2002).

Hence, Thomas et al. (2002) did a qualitative study of eight inpatients in an acute psychiatric ward and found that the essential meaning of the hospital to patients was a refuge from self-destructiveness. Unlike other medical patients who saw the hospital as confining (Shattell 2002), psychiatric patients experienced it as freeing, as a ‘safe house’ (Thomas et al. 2002). Other positive experiences were feeling solidarity with other patients and socialising with them. Interactions with professional staff tended to be superficial and there was a yearning for greater closeness. Making connections with staff appeared to be contingent upon personal qualities of those members, such as a willingness to give attention, time and information and being experienced as warm, gentle, kind, friendly, supportive and willing to laugh (Thomas et al. 2002).

Opportunities to talk with other patients provided greater satisfaction than any other aspect of hospital experience measured (Howard et al. 2001). In the study by McIntyre, Farrell and David (1989) simply talking to a caregiver, be he/she a nurse or a doctor, was widely regarded as the most helpful aspect of care. Drug treatment was judged on average to be

only “quite helpful” (McIntyre et al. 1989: 160). They recommend paying as much attention to ‘talking therapy’ as to other aspects of help. A South African qualitative study of 13 psychiatric patients found that patients missed a close relationship and that nurses were perceived as enforcers of rules (Müller and Poggenpoel 1996).

Satisfaction with health care services has, as described, been assessed in a number of different ways. Some studies, however, have defined satisfaction as willingness to recommend the health care facility where one was treated (Klinkenberg et al. 2011). Willingness to recommend is a measure of behavioural intentions and may better predict return to the provider than assessments of overall satisfaction. The sample Klinkenberg et al. (2011) studied included survey data collected between July 2007 and June 2008 for 131 hospitals and 33 445 patients. The primary outcome was willingness to recommend the hospital to family and friends.

Perceptions of nursing care have been correlated with overall satisfaction with inpatient care nearly every time they are measured. Patients who report positive perceptions of nursing care are much more likely to report high satisfaction with overall care. Klinkenberg et al.(2011) write that their results support this body of work. Survey items that assess patient perceptions of nursing care are among the top predictors of willingness to recommend. Their results also support previous research in which perceptions of physician care have been the next most important predictor of patient satisfaction. The way doctors communicated and their attention to interpersonal factors are important, for example, the item ‘physicians showing courtesy and respect’ had a strong relationship with willingness to recommend.

Interpersonal aspects of care were thus the strongest predictors of willingness to recommend, especially perceptions of nursing care. This is not surprising, since hospitalised patients feel emotionally very vulnerable and may have basic fears about their physical security and safety; this emotional state may provide an important lens through which patients view their care experiences. Klinkenberg et al. (2011) end by stating that caregivers who are sensitive to the emotional state of patients and respond attentively and with compassion may therefore be remembered more favourably than whether the bathroom was clean enough.

## 8.4 CENTRAL ASPECTS OF RELATIONSHIPS

### 8.4.1 Existence as “being-in-a-relationship”

The immediate, direct relationship to the other is pivotal in the thinking of the Jewish philosopher Martin Buber (1878 -1965). In his famous book, *I and Thou*, Buber (1984) explores various types of encounters. Existence, he writes, means encounter, but there are two kinds of encounters: there is the world of *I–Thou* and the world of *I–It*. There is, according to Buber, no *I*, no *Thou* and no *It*, because no one and nothing exists in isolation. The *I* exists only as *I–Thou* or *I–It*. The *I* in *I–Thou* and *I–It* is however not the same *I*; it is a different *I*. An *I–Thou* existence means to be in a relationship with another human being; being in such a relationship involves the *whole* person, the person in his *totality*. An *I–It* encounter, however, is not a full relationship - it is an encounter with *something* and never involves the *whole* person.

In the beginning, states Buber (1984), is the relationship. A relationship is needed for inner growth. He writes (Buber 1984: 32): “Der Mensch wird am Du zum Ich.” Directly translated this would be: in the interaction with a ‘You’, a human being develops into an ‘I’. What I think Buber means, is that a human being develops into a person through the connection to another person.<sup>17</sup>

The psychoanalyst Donald Winnicott (1896-1971) comes from a different angle, but states something similar. Winnicott, initially a paediatrician, concentrated his research on the area of earliest infancy and the importance of the mother-child relationship. According to him, there is no such thing as an infant, meaning that whenever one finds an infant, one finds maternal care; neither an infant nor a mother exists in isolation, only in a mother-infant unit (Winnicott 1960). It is *only* in such a relationship that a human being can develop.

Existence as ‘being-in-a-relationship’ is thus emphasised. Psychopathology, however, leads to isolation and withdrawal (Van den Berg 1972; Böhmer 2010).

---

<sup>17</sup> I discuss in Section 8.6.4 the difference between ‘a person’ and ‘a someone’.

### 8.4.2 Mirror neurons

In experiments with monkeys, Di Pellegrino et al. (1992) discovered a particular set of neurons in the motor and premotor area of the frontal lobe which discharged both during the monkey's active movements and when the monkey observed goal-directed hand movements made by the experimenter, e.g. picking up an object. They called these neurons 'mirror neurons' and proposed that mirror neurons form a system for matching observation and execution of motor actions (Gallese et al. 1996).

Neuroscientist Giacomo Rizzolatti, who with his colleagues (Di Pellegrino et al. 1992) at the University of Parma first identified mirror neurons, says that the neurons could help explain how and why we 'read' other people's minds and feel empathy for them (Winerman 2005). Over the past decade, more research has suggested that mirror neurons might help explain not only empathy, but also autism and even the evolution of language (Winerman 2005). Matching is the most basic property of mirror neurons; they fire when the monkey observes and performs similar actions. The matching property of mirror neurons promotes action understanding, because it puts the observer in the same causal state as the actor. "Mirror neurons seem to bridge the gap between one agent and another; to represent 'my action' and 'your action' in the same way" (Heyes 2010: 575).

Heyes (2010), wondering about the origin of mirror neurons, explores two options. Mirror neurons could be an adaptation, because they helped individuals to understand what others were doing, or they are a product of associative learning, through the experience of observing others and executing the same action.

Is there a human mirror neuron system? Heyes (2010) mentions that research using transcranial magnetic stimulation (TMS) and functional magnetic resonance imaging (fMRI) has been interpreted by many researchers as evidence that humans also have mirror neurons or a mirror neuron system. Other researchers have recently, however, challenged the existence of a human mirror neuron system and more research is needed (Heyes 2010).

If the associative hypothesis is correct, mirror neurons not only support, but are supported by, human sociality. They come, not from evolution, but from

sensorimotor experience, and much of this experience is obtained through interaction with others. Therefore, the associative account implies that mirror neurons are a product, as well as a process, of social interaction (Heyes 2010: 581).

### **8.4.3 Attachment**

Attachment theory, developed by Bowlby, describes how individuals when threatened or ill seek proximity to a wiser, stronger 'secure' base for protection (Holmes 2010). Attachment behaviours serve to protect the young from danger; these early experiences become internalised as mental representations or internal working models of future relationships (Hooper et al. 2012).

Bowlby conceived of the attachment system as an inborn instinctual system that directs the infant to seek proximity to and communication with the mother (Kandel 1999). Numerous studies with animals have contributed to an understanding of social interaction, for example the (in)famous experiments of Harlow in which he isolated young Rhesus monkeys from their mothers, which led to social deficits in these monkeys, demonstrating the importance of social interaction and care-giving (Harlow and Harlow 1969; Kaplan and Sadock 2005). In an experiment on attachment in dogs, Levine found that an increase in attachment behaviour in the first two weeks of a pup's life reduced the hypothalamic-pituitary-adrenal response to stress for the rest of the pup's life (Levine et al. 1967). Concomitantly it reduced the pup's fearfulness and vulnerability to stress-related disease (Liu et al. 1997; Plotsky and Meaney 1993). By contrast, when the pups were separated during these first two weeks from their mothers for prolonged periods of time the pups showed an increase in plasma adrenocorticotrophic hormone (ACTH) and glucocorticoid responses to stress as adults.

Kandel (1999: 514) writes: "Here we have a remarkable example of how early experience alters the set point for a biological response to stress." Furthermore, repeated stress and elevated glucocorticoids over a number of weeks causes atrophy of the neurons of the

hippocampus; over years this can lead to permanent damage and significant impairment in memory (Kandel 1999).

Attachment theory was initially focussed on infants and children; young toddlers were classified as either securely or insecurely attached. With further research, this was extended to adults. Attachment patterns are nowadays described as secure, insecure avoidant, insecure ambivalent and disorganised (Holmes 2010). In secure attachment, a child will internalise beliefs of the world as a safe place and others as caring and reliable. Consequently, they will feel secure enough to independently go and explore their environment and to build as adults secure social relationships. Attachment patterns have a clear influence on the development of the personality and are directly associated with mental and physical health in adulthood (Hooper et al. 2012). A secure attachment style should serve as a protective factor during times of distress.

However, if the attachment figure is experienced as cold, unresponsive and unavailable, the child will not develop a sense of secure attachment and will form a negative working model of him or herself and others. In this case, individuals will have to develop alternative strategies to relieve distress rather than seeking proximity to the attachment figure (Smith, Msetfi and Golding 2010).

Bowlby (1988) drew parallels between the role of the parent and the role of the therapist. Like a parent, the therapist is viewed as needing to provide a secure base for the client, which would then allow the client time, space and safety to explore and develop a greater understanding of themselves and the world. Patients with a secure attachment pattern are thought to engage more easily with therapy; conversely, clients with an insecure attachment pattern may avoid interpersonal closeness with the therapist, or worry about the therapist's investment in them. As a result, this may delay the formation of a good quality alliance and impede the therapy.

Attachment theory can thus be seen as a possible approach to explore the therapeutic alliance; it offers a framework to study patients' interpersonal characteristics and their capacity to form positive relationships (Smith et al. 2010). Understanding a patient's

attachment style may help providers better anticipate or predict how best to relate to this patient. Attachment styles can influence the relationship between patient and physician and consequently the outcome of treatment (Hooper, Tomek and Newman 2012).

Different terms are unfortunately used by various authors to describe the different attachment styles. Hooper et al. (2012) describe the different attachment styles and effects on the therapeutic alliance as follows:

- **Secure attachment:** The internal working model of these patients is one of trust and these patients have the most effective and beneficial relationships with their physicians.
- **Insecure attachment:** Insecure internal working models derive from poor and inconsistent parental caregiving. These people have difficulty regulating their emotions and have limited coping strategies. Patients with an insecure attachment style can at times be overly argumentative, avoidant, or overly dependent and anxious.

Insecure attachment can be divided into:

- **Insecure-dismissing attachment:** They have a negative view of others and expect that people will reject or ignore any attempts to get help and support. These patients tend to deny or downplay symptoms or illnesses; they may avoid seeking support and remain disengaged, focussing rather on independence and on being self-sufficient. They are undemanding, although they may show hostility and fail to comply with treatments. Physicians can make the mistake of spending less time with them due to their undemanding attitude.
- **Insecure-preoccupied or avoidant attachment:** As children, these people often experienced rejection; they developed into people emotionally dependent on others' acceptance and approval and can be 'clingy' and exaggerate their needs.
- **Insecure-fearful attachment:** Such patients usually had a harsh and rejecting childhood. They may feel unworthy of care and view caregivers as potentially threatening or hostile. Because of their interpersonal anxiety and mistrust, they are not willing to form a therapeutic alliance and can leave a physician with feelings of incompetence and frustration.

In relation to clients' global attachment patterns there is evidence to suggest that the more secure clients are in their attachment relationships the better the quality of the alliance they form with their therapist. However, there is more uncertainty about the effects of insecure attachment on the alliance, although there is evidence to suggest that having an avoidant attachment pattern reduces the strength of the alliance (Smith et al. 2010). One important factor neglected in this review is the contribution of the therapist's attachment pattern to the therapeutic alliance, an area that needs further research.

#### 8.4.4 Empathy

Dorland's Medical Dictionary (1974) defines empathy as "the recognition of and entering into the feelings of another person".

Empathy is defined by the American Psychoanalytic Association as: a mode of perceiving by vicariously experiencing the psychological state of another person. Literally, it means 'feeling into' another person, as contrasted with *sympathy*, which means 'feeling with' (Moore and Fine 1990).

Mercer and Reynolds (2002) describe empathy as the ability to:

- (a) Understand the patient's situation, perspective, and feelings (and their attached meanings);
- (b) To communicate that understanding and check its accuracy; and
- (c) To act on that understanding with the patient in a helpful (therapeutic) way.

According to them empathy can be improved and successfully taught at medical school, especially if it is embedded in the students' actual experiences with patients.

The concept of empathy needs to be differentiated from other emotional responses of the psychiatrist or therapist to the patient. The term 'emotional response' can, according to Colli et al. (2014), be used interchangeably with 'emotional reaction' or 'countertransference'. A patient can engage with the clinician in a manner that leads the

therapist to experience specific emotions and thoughts. Colli et al. (2014) found a significant and consistent relationship between therapist reactions and specific personality disorders. Therapists' reactions can for example be feeling helpless, incompetent, overwhelmed, disengaged or nurturing. This response can inform both diagnostic and therapeutic interventions, e.g. feeling incompetent and overwhelmed by a patient with a borderline personality disorder.

Goldberg (2011) quotes the *American Heritage Dictionary*, where empathy is defined as “understanding so intimate that the feelings, thoughts and motives of one are readily comprehended by another.” The definition of empathy has however changed over times (Goldberg 2011). Empathy is more than a cognitive act, is not a mere registration of thoughts and feelings; one should rather talk of empathic understanding as a process by which one person gets to know another. Kohut introduced the concept of *sustained empathy* (Goldberg 2011: 291). Goldberg compares ‘ordinary empathy’ to a snapshot and ‘sustained empathy’ to a video - the lengthy immersion of a person in another’s psychological state. Sustained empathy, or in Goldberg’s words *sustained empathic understanding*, is not only quantitatively different, but also qualitatively. Being empathic with another person does not occur in a slice of time, it is rather an unfolding story. It is not a matching of feelings with a resultant understanding, but rather a complex configuration of a story told over time.

Thus one needs to sustain and modify empathy to achieve understanding. Empathy changes over time, and alone it explains little. Empathy should be viewed as yielding data to be carefully organized in terms of cause and effect, sequencing and goals. If used in isolation it is but a form of attunement or affective resonance that need have no meaning on its own. Its universality should not be taken to indicate any particular therapeutic benefit. As an isolated event, being empathic may have a good effect, lead to misunderstandings, or make little difference therapeutically (Goldberg 2011: 295).

Sharing feelings, appreciating feelings and responding to feelings are three essential components of empathy and add up to understanding.

Empathy is a two-way street: we observe and participate in an interaction with another person (Goldberg 2011). This interaction demands of the person practicing sustained empathy to avoid premature closure; that is to tolerate anxiety or any negative or positive feeling aroused and to understand and manage the fantasies stimulated by the effort. Greenson (1960) elaborates on this two-way relationship, stating that one's capacity for empathy can be influenced by the other person's resistance or readiness for empathic understanding. There are patients who consciously and unconsciously do not want to be understood, they dread being understood. For them to be understood may mean something negative and frightening, e.g. being destroyed or unmasked.

Greenson (1960) writes that in order to carry out effective psychotherapy a knowledge of theory and the intellectual understanding of a patient is not sufficient, one has to know a patient differently, that is emotionally.

One cannot truly grasp subtle and complicated feelings of people except by this 'emotional knowing'. It is 'emotional knowing', the experiencing of another's feelings, that is meant by the term empathy. It is a very special mode of perceiving. Particularly for therapy, the capacity for empathy is an essential prerequisite. ... To empathize means to share, to experience the feelings of another person. This sharing of feeling is temporary. One partakes of the quality and not the degree of the feelings, the kind and not the quantity. It is primarily a preconscious phenomenon. The main motive of empathy is to achieve an understanding of the patient (Greenson 1960: 418).

Greenson (1960) describes two types of disturbances in the capacity for empathy:

- i. **Inhibition of empathy:** A repeated difficulty in recognising the affects and motives, particularly the subtle affects and unconscious motives of patients. This can be transient or chronic, generalised or localised. The transient and localised inhibitions of empathy have a good prognosis, whereas the chronic and generalized inhibitions have a poor prognosis. Empathy means to share and participate, to become involved in the

emotional experiences of the patient. For certain therapists, this might cause too much anxiety.

- ii. **Loss of control of empathy:** the therapist begins by being able to empathise with his patient, but this empathy does *not* lead to understanding and addressing the necessary issues in therapy; other reactions intervene, such as the picking up of hostile feelings in the patient, and the understanding is either blocked or is misused. The loss of control refers to an intense involvement leading to counter-transference acting out. There is a difficulty to move from being a participant to being an observer.

The therapists in the first group are afraid of their countertransference and inhibit their reactions. The 'uncontrolled' therapists of the second group give in to and act upon their countertransference reactions instead of using them for the psychotherapeutic work.

In any psychotherapeutic work “one not only empathises with the patient, but one needs to do so with the other significant persons in the patient's life; only in this way can one form some perspective and be able to evaluate the patient's behaviour” (Greenson 1960: 422).

Greenson ends with several questions and statements, two of which are:

- i. Is empathy teachable? One can remove inhibition and misuse of empathy, but the *capacity* for empathy cannot be taught. If it is available a person can be taught how to use it properly.
- ii. Since empathy originates in the early mother-child non-verbal communications, it has a definite feminine cast. To be empathic, men must have come to peace with their motherly component.

Interesting research on empathy was done by Preston, Hofelich and Stansfield (2013). They note that empathy is inherently interpersonal, but the majority of research has only examined observers and not targets of need. Their ‘targets’ were not hypothetical and fictionalised depictions of distress and need, but real hospital patients with serious chronic or terminal illness. The patients or ‘targets’ were classified through their expressed affect into five types: distraught, resilient, sanguine, reticent and wistful. These types elicited four major emotions in observers (*treaters*): personal distress, empathic concern, horror and

pleasure. *Distraught* targets, although mostly disliked, usually received the greatest aid, but nearly as many observers preferred the positive and likeable *resilient* patients or the wistful targets.

The emotional response of observers to patients in need interacted with the preferences of the observers. Past research, they write, aimed to prove the existence of a 'pure' form of altruism. Taking note of research from economics and evolutionary biology, they found that clearly distressed targets may actually be passed over in favour of more positive ones when the latter are viewed as offering greater potential return rewards. Cooperation and reciprocity or a cost-benefit analysis may play a role in favouring positive over distressed targets, unlike in empathy-altruism theories.

An interactionist view of social behaviour is supported in which the interaction between observer and target dictates the response. Help is optimally elicited by intermediate levels of distress shown by patients, but impeded by too little or too much. Observers with lower emotion-regulation skills may also be more likely to avoid distraught patients.

Empathy relies thus on the professional's communication skills, on the ability to pick up patient cues and to respond accurately (Egan 2002; Norfolk, Birdi and Walsh 2007). It is a core element of patient-centred communication. Greater empathy in the consultation leads to higher agreement about decisions as well as recall of decisions. Patients of physicians who scored high on empathy had a significantly lower rate of acute metabolic complications than patients of physicians who scored moderate or low on empathy. This was the finding of Del Canale et al. (2012) in a retrospective correlational study that included 20 961 patients with type 1 or 2 diabetes mellitus treated by 242 physicians. Hojat et al. (2011) found that patients of physicians with higher empathy scores had better control of their A1c haemoglobin levels than patients of physicians who scored low on empathy.

Developing empathy may lead to improvement of long-term patient outcomes; training in communication skills is thus important (Parkin, De Looy and Farrand 2014).

## Empathy training

Empathy training is not specifically taught in most undergraduate or graduate medical programmes (Riess et al. 2012). As mentioned, Greenson (1960) states that the *capacity* for empathy cannot be taught. Riess et al. (2012), however, write that specific brain circuits have been shown to be associated with empathic behaviours; changes in these circuits correlate with the decline in empathy that some researchers have found in medical students over the years of training. Riess et al. (2012) thus developed an empathy and relational skills training protocol grounded in the neurobiology of emotions. The aim of this was to improve physicians' skill in detecting subtle non-verbal signs of emotions in themselves and their patients and to respond in helpful ways.

A total of 99 residents and fellows from six medical disciplines were randomised to standard postgraduate training or training augmented with three 60-minute empathy training modules. Each physician was rated by multiple patients. The result was that the empathy training group showed greater changes in patient rated Consultation and Relational Empathy (CARE) scores than the controls. The ability to decode subtle facial expressions of emotions also significantly improved. Riess et al. conclude that although the standardised effect size was modest, the change in empathy scores may indicate that such virtues can indeed be taught.

### 8.4.5 Language

Language is important to patients. They feel at home in a certain language and can express themselves better in it; maybe also because they feel safer in this language.

Discussing language and identity Verhaeghe (2004) lists the following functions of language:

- i. **Mastery:** the child, initially helpless, acquires an active hold on the external world through a process of representation, which begins with crying and continues in speech. "Language, and even more representation, opens up the possibility of regulating affect"

(Verhaeghe 2004: 173). Imaginary constructs are developed in an attempt to give meaning, to get a grip on aspects of this world. Naming something is however not the same as understanding it. Verhaeghe adds a note that this is a quote from the Nobel Prize winner Richard Feynman and that he, Verhaeghe, highly recommends this to DSM devotees.

- ii. The second function of language concerns **identity**. “Our identity is verbal; each human being is a story and lives in a narrative reality” (Verhaeghe 2004: 174).
- iii. The third function is **communication**, and here the important thing is “not so much the message but rather the relation between the sender and receiver” (Verhaeghe 2004: 175). This relation will determine how the message is received – or not, and whether it is ‘taken in’ and kept or rejected.
- iv. Language also opens up the potential for **consciousness**. Verhaeghe (2004) means this in a psychoanalytic sense. He writes (p. 176): “The ‘taking in’ and ‘retaining’ of the positive signifiers of the Other implies consciousness, the ‘sending out’ of the Other’s negative signifiers implies that they become unconscious (again).” Human language gives one the ability to reflect, to think about oneself and the other from a distance, thus making choices possible.

If the doctor does not speak the language of the patient, it can severely impair their interaction. Swartz (1998: 25-26) tells the following story of his research in a large general hospital in Cape Town. A psychiatric registrar was trying to interview a Xhosa patient. Because of language difficulties he had to call in the patient’s relative to interpret. The relative, however, also struggled with English, so the registrar called in the Xhosa-speaking cleaner. He did not want to be rude to the relative, so he allowed him to stay and the interview thus proceeded as follows: the registrar asked a question in English, the cleaner translated it in Xhosa to the relative, who, also in Xhosa put the question to the patient. The answer came back the reverse route; that is, patient to relative to cleaner to registrar. At the end of the mental status examination, the registrar asked an unusual question: “Who am I?” Forward went the question and back again through the various relays came the answer: “You are a secretary.” Swartz concludes that the patient was correct: this was not a healing encounter.

#### 8.4.6 Verbal and non-verbal behaviour

...the initial communications between patient and doctor, which are crucial in determining whether a relationship of trust develops, may very well be non-verbal, conveyed by manner, facial expression, gesture, or posture (Argyle 1972; Fraser 1976) in the same way that infant and mother communicate and establish a relationship before attaining a common verbal language. Interest, respect and reliability are not conveyed by words alone (Bateman, Brown and Pedder 2010: 95).

Psychoanalysis or psychoanalytic psychotherapy is (also) about finding words to express that which was up to now inexpressible. The title of the fascinating autobiographical novel of Cardinal (1993), telling about her psychoanalytic journey, is conveying this: *The words to say it*. But words can also be used to conceal the truth, “which is why we use the more primitive and sometimes more truthful non-verbal signs to check on the validity of communications” (Bateman et al. 2010: 95).

Both therapist and patient take note of any discrepancies between what is said and how it is said (Bateman et al. 2010.) Any such discrepancies will negatively influence the developing therapeutic alliance.

In an interesting study, Pawlikowska et al. (2012) studied verbal and non-verbal behaviour linked to patient outcomes. The concept of patient enablement is based on the idea that patient outcome is largely influenced by how patients feel after a consultation: has the consultation increased their understanding and / or their ability to cope with their illness? Patient enablement was first described by Howie, Heaney and Maxwell (1997). Doctors who spend more time at consultations were found to be more patient centred and enabled their patients more.

In their study Pawlikowska et al. (2012) found an association between patient enablement and the following:

- **Socio-emotional interchange:** agreements, approval, laughter and legitimisation (e.g. acknowledging the patient's feelings).
- **Task-related behaviour:** patient education and counselling by the physician and patients requesting services.
- **Patient centeredness.**
- **Verbal dominance** by the patient and high affiliative and less controlling behaviour by the doctor.
- **Body language:** 'relaxed hands'; that is not busy writing or typing and thus being attentive.

In summary, patient enablement is facilitated by appropriate information exchange, personal connection, an engaged patient and an attentive doctor. These aspects however only account for 33 per cent of the variance of enablement. Further research is thus necessary to clarify this. It is important for physicians to support patient enablement by attending to these factors.

Swartz (1998: 42) notes that non-verbal behaviour can tell us a lot about how people feel and that "interviewers not conversant with the language of a client are also often unaware of the rules for nonverbal behaviour in that client's culture". Even note taking might influence the interaction and should be discussed with the patient.

#### **8.4.7 Holding, containment, or keeping someone in mind: a psychoanalytic perspective**

Winnicott (1971) described the role of the mother (and family) in the development of the infant as:

- Holding
- Handling
- Object-presenting.

The mother, according to Winnicott, provides a 'holding environment' within which the infant is contained (Greenberg and Mitchell 1983). Healthy development depends on this.

For Ogden (2004) Winnicott's idea of 'holding' and Bion's concept of 'container – contained', though often used interchangeably, address quite different aspects of the same human experience. These two concepts do not stand in opposition to one another, but are two vantage points from which to view emotional experience. The word 'holding' evokes tender images of a mother cradling her infant in her arms; tightly holding him or her when he or she is under distress.

Holding, for Winnicott, is an ontological concept that he uses to explore the specific qualities of the experience of being alive at different developmental stages as well as the changing intrapsychic–interpersonal means by which the sense of continuity of being is sustained over time. (Ogden 2004: 1350)

In Winnicott's term 'primary maternal preoccupation' allows the infants 'going on being'; the mother shields the infant from the awareness of the 'not-me', an unbearable awareness at this stage of life. For the time being an illusion is created, "the illusion of a world in which time is measured almost entirely in terms of the infant's physical and psychological rhythms" (Ogden 2004: 1351). The emotional growth of the infant is dependent on this maternal 'holding'.

At its core, Winnicott's holding is a conception of the mother's/analyst's role in safeguarding the continuity of the infant's or child's experience of being and becoming over time. Psychological development is a process in which the infant or child increasingly takes on the mother's function of maintaining the continuity of his experience of being alive. (Ogden 2004: 1362)

This leads to the gradual internalisation of a holding environment.

Ogden (2004) writes that Bion's idea of the container–contained addresses not *what* we think, but the *way* we think, that is, *how we process* lived experience (my italics). "Bion is suggesting that the human personality is constitutionally equipped with the potential for a

set of mental operations that serves the function of doing conscious and unconscious psychological work on emotional experience (a process that issues in psychic growth).” (p. 1355). The ‘container’ is not a thing, but a process; it is the capacity for unconscious psychological work, operating in concert with the capacity for pre-conscious dreamlike thinking (reverie) and the capacity for more fully conscious secondary-process (reality-based, logical) thinking.

The ‘contained’ is also not a static thing, but a living process that Ogden describes as continuously expanding and changing. The term refers to thoughts (in the broadest sense of the word) and feelings derived from one’s lived emotional experience.

In Bion’s hands, the central concern of psychoanalysis is the dynamic interaction between, on the one hand, thoughts and feelings derived from lived emotional experience (the contained) and, on the other, the capacity for dreaming and thinking those thoughts (the container). The aim of psychoanalysis from this perspective is not primarily that of facilitating the resolution of unconscious conflict, but facilitating the growth of the container–contained. (Ogden 2004: 1359)

Levine (2007) underlines the importance of containment; a lack of which might cause the analysis to not survive:

According to Bion, the therapeutic action of psychoanalysis ...is closely linked to the analyst's function as container for the patient's unmetabolized and projected emotional experience. In order to perform this function, the analyst must keep intact his or her capacity to absorb, bear, and make sense of that which is inchoate, unbearable in, and projected by the patient. If the patient's projections begin to overwhelm and outstrip the analyst's capacity to withstand, absorb and process them, the analyst may become dysfunctional. ...Whatever the form of the problem and its underlying dynamics, the common challenge these patients have presented is that of analytic survival: how to maintain an adequate degree of functioning as a containing, thinking, and analyzing analyst. (Levine 2007: 983-5)

The container-contained relationship constitutes Bion's model for the development and thinking of thoughts (Waddell 1998). The mother contains the intolerable emotional experiences of the infant by taking them inside her own mind, tolerating it, processing it and ultimately giving it back to the infant in a modified and tolerable form (Bion 1962a; 1962b; Ogden 1986; Symington and Symington 1996). Impulse life becomes bound by thought. Initially the mother thinks for the infant, but slowly the infant learns to perform that function for himself. Waddell (1998: 32) describes how this process is captured in Barrie's description of Peter Pan:

Mrs Darling first heard of Peter when she was tidying up her children's minds. It is the nightly custom of every good mother after her children are asleep to rummage in their minds and put things straight for the next morning, repacking into their proper places the many articles that have wandered during the day. If you keep awake (but of course you can't) you would see your mother doing this, and you would find it very interesting to watch her. It is quite like tidying up drawers. You would see her on her knees, I expect, lingering humorously over some of your content, wondering where on earth you had picked this thing up, making discoveries sweet and not so sweet, pressing this to her cheek as if it were as nice as a kitten, and hurriedly stowing that out of sight. When you wake in the morning, the naughtiness and evil passions with which you went to bed have been folded up small and placed at the bottom of your mind; and on the top, beautifully aired, are spread out your prettier thoughts, ready for you to put on. (Barrie 1911: 12)

This is a beautiful description of the functioning a mother provides for her child, of the child's thoughts being 'sorted' by a mind capable of holding and understanding his mental states (Waddell 1998). The mother has her child *in mind*, she thinks for the child and provides containment.

A similar process happens in psychotherapy. Holmes (2010) writes that containment and holding reflect the secure base that the therapist must provide to make exploration possible. This sense of security is of utmost importance. Containment means that there is

someone who is able to contain, to manage what we are not yet able to manage ourselves (Casement 2006). Feelings experienced without containment tend to be overwhelming and frightening (Klein 1987). Providing containment means for a therapist to not back off in a session from happenings that produce intense anxiety (Casement 2002). It also means to first *receive* feelings and not to interpret them *instead* of receiving them (Klein 1987).

According to Casement (1985), when people cannot cope with their own feelings, the help being searched for is always for a *person* to be available to help with these difficult feelings. Medication can subdue these feelings, but this does not change anything for a patient who still feels victim to powerful feelings. A *personal* form of containment is looked for. What is needed is a form of holding, such as a mother gives to her distressed child (Casement 1985). If a mother is not able to be in touch with her infant's unbearable state of mind, if she too cannot bear it, then the infant is not helped to make the situation more manageable (Bion 1962b; Casement 2006). The infant's experience is rather made worse; Bion referred to this as an experience of 'nameless dread' (Bion 1962b).

In psychoanalysis, a distinction is being made between giving a patient an interpretation and providing containment. La Farge (2000) calls this distinction a somewhat artificial one. Interpretation, she writes, always rests in part upon containment and interpretation is always also an act of containment. Interpreting something to a patient implies that there is some understanding, and understanding someone is providing containment. That is what Casement refers to when he talks about the need for a person. "...in analytic work we have to find ways of containing a patient through words, and through the nature of our attitude and presence in a session, without having to resort to physical measures" (Casement 2006: 82). Casement however also states that there are situations in which limits (boundaries) are essential for containment.

Containment is also linked to contentment. In describing the smiling of a baby, Balbernie writes: "Early smiling ...is a cheerful sign of being (a) content" (Balbernie 1997: 251). I interpret Balbernie's statement as follows:

- Smiling is a sign of being content: No interpretation needed.

- Smiling is a sign of being a content: A baby can smile if he or she has the ‘knowledge’ of being ‘a content’; that is, the baby ‘knows’ that he or she is being held and contained, the baby-content is held by the mother-container.

It is interesting to compare the origin of the words ‘contain’ and ‘content’ (Oxford Dictionary of English 2005). Their roots indicate them being linked:

Contain, from Latin *continere*, from *con-* ‘altogether’ + *tenere* ‘to hold’.

Content<sup>1</sup>, from Latin *contentus* ‘satisfied’, past participle of *continere*.

Content<sup>2</sup>, from Latin *contentum* ‘things contained’, neuter past participle of *continere*.

One could say: He or she is contained who is content. Or: He or she is content who is contained. For me this links to the comments one patient made that a therapeutic connection can be established immediately and that this depends mostly on the “weselikheid”, that is on the essential being of the physician / registrar. Is he or she content? Then he or she will be able to contain – themselves and patients. (Obviously, up to a certain degree, to temper any idealism.)

Containment is also linked to boundaries. Having boundaries or limits provides safety in psychotherapy and in the hospital.

#### **8.4.8 From holding to being remembered and the continuity of life**

A child needs to know that he or she is kept in mind or remembered by mother; this allows the child to develop self- and object constancy. Bach (2001) describes this in a wonderful metaphor:

It was then that I realised that a person's specific memories and experiences are like individual beads that can achieve continuity and gestalt form only when they are strung together to become a necklace. The string on which they are assembled is the child's continuous existence in the mind of the

parent, which provides the continuity on which the beads of experiences are strung together and become the necklace of a connected life. (Bach 2001: 748)

“When this process is deficient the child, and later the adult, may experience discontinuities of the self ...” (Bach 2001: 749). This can show itself in psychotherapy by, for example, the patient often assuming that the therapist has forgotten what he or she has told him or her. Another example is a patient of mine who regularly forgot how I looked. Life is not connected and is in danger of fragmentation. In psychotherapy, therapist and patient have to work together to keep each other alive in memory (Bach 2001). For such patients the frequency of sessions is important.

## 8.5 THE THERAPEUTIC ALLIANCE

Studies about psychotherapy found that all the major types are effective, which led to a search of the common ingredient of these psychotherapies (Winston, Rosenthal and Pinsker 2004). The common element is the therapeutic alliance; if there is not a good alliance, little is accomplished. In establishing such an alliance and in the assessment and treatment of the patient knowledge about the personal and intra-psychic life of the patient is of crucial importance (Gabbard 2005; Kay 2006; Böhmer 2011).

To try and help with an overview of this broad topic I shall discuss it under the following headings:

- Definitions and descriptions
- Why does it matter?
- Trust
- The particular *place* of therapy or consultations
- Social class
- Different models of interacting with patients
- The intercultural and interracial therapeutic relationship
- First consultations and frequency of being seen: Comments from a psychoanalytic point of view.

### 8.5.1 Definitions and descriptions

The therapeutic alliance, according to Smith et al. (2010), refers to the interpersonal processes that occur in the relationship between a psychotherapist and patient. The concept of the therapeutic alliance was originally developed within the psychodynamic tradition. Research indicates, however, that a good quality therapeutic alliance is related to a more positive therapeutic outcome independent of the type of therapy delivered.

Smith et al. (2010) write that differences in the way that researchers conceptualise and term the therapeutic alliance (e.g. working or helping alliance or therapeutic *relationship*) have led to the call for a clarification of the concepts underlying the alliance in order to provide a cohesive definition. Bordin (1979) states that the strength, rather than the kind of working alliance, is the major factor in change achieved through psychotherapy. The strength of the alliance is a function of the goodness of fit of the respective personalities of patient and therapist to the demands of the working alliance. Bordin (1979) presented a generic synthesis of alliance constructs and conceptualised it as a purposeful collaborative relationship that involves a blend of three features:

- i. An agreement between the therapist and client on the goals of therapy
- ii. An agreement of a task or tasks that can be done to achieve these goals
- iii. The development of a bond; that is the development of enough trust, respect, confidence and personal attachment between the therapist and the client to achieve the goals and take part in the tasks.

### 8.5.2 Why does it matter?

Why does a patient-doctor relationship matter and how is it achieved? Mikesell (2013) asks these questions. According to her current discussions focus on *indirect* effects of the patient-doctor relationship (PDR), for example better adherence to a treatment plan and treatment satisfaction, but disregard the potential *direct* effects of the PDR on patients' health and well-being.

Mikesell (2013), quoting research on the topic, states the following:

- Social support has powerful direct effects on psychological well-being as well as on morbidity and mortality. The feeling that someone ‘is there for one’ reduces mortality by at least 33 per cent and probably cuts mortality rates in half. The person who is there for the patient could be the doctor; the PDR can have a direct therapeutic effect.
- Patient satisfaction is highly influenced by attributes of the PDR, more so than by characteristics of other domains, such as the medical care facility. Yet it is not clear what satisfies patients. Not all want, for example, shared decision-making; certain older patients prefer doctors to be in control of treatment decisions. Doctors should therefore be careful to not make assumptions too easily regarding patient preferences, but should ask patients what information they want and how they want to make decisions.
- However, what seems to be clear is that patients want to feel cared for and listened to. Waitzkin (1985) found that doctors underestimated patients’ desire for information and the time they dedicated to information giving. In 336 encounters, doctors dedicated 80 seconds to providing information or explaining problems, yet they estimated that they had spent nine minutes on this. A greater awareness of what is happening is needed.
- PDR and communication seem to be more important to patient satisfaction than doctor characteristics such as age or experience.
- Although many studies focus on a ‘patient-centred’ approach, what seems to matter most is that patient and doctor agree upon and utilise a similar communication or relationship style. The key to building a successful professional relationship seems to be a dynamic and collaborative effort by both doctor and patient to define the framework of their interactions. Physicians thus have to listen to the way the patient approaches the medical encounter, not only to what they say and to adapt their style to fit the patient.
- A single open-ended question such as “What can I do for you today”, can help to discover the patient’s orientation towards the PDR and leads to patients opening up more than if asked leading, confirmatory, or closed questions. Additional concerns then need to be followed up. Heritage et al. (2007) found that a single word could make a difference: patients responded better to “Is there *something* else you want to address today?” than “Is there *anything* else you want to address today?” the latter being a negative polarity question.

- Body language, e.g. eye contact, is also an important way to communicate interest and attention. When and how a physician attends to medical records (reading, writing) is thus also important.

The treatment process therefore requires a high-quality relationship in which trust, the quality of both non-verbal and verbal communication, as well as allowing the patient time to think, are facilitating factors.

According to Bordin (1979), the process of building and repairing a strong alliance is the key mechanism underlying therapeutic change. He viewed the alliance as dyadic and mutual with the therapist and client as active co-constructors, constantly negotiating and renegotiating the alliance in order for successful work to take place (Bordin 1994). Smith et al. (2010) write that research has tried to identify factors that influence this relationship, in particular pre-treatment individual differences of patients, such as motivation or the ability to form social relationships. Attending to such factors might improve the efficacy of therapy. Research has shown that a strong therapeutic alliance in psychotherapy and pharmacotherapy has a significant effect on outcome (Krupnick et al. 1996; Cape 2000). In a study of 72 patients with mostly psychotic disorders, a better outcome was achieved for patients who experienced the helping alliance more positive (Priebe and Gruyters 1993).

A ground-breaking analysis of outcome data found that the most effective one-third of psychiatrists achieved better outcomes with placebos than the least effective one-third of psychiatrists achieved with active antidepressants (Mintz and Flynn 2012; McKay, Imel and Wampold 2006). The researchers concluded that the psychiatrist as a *person* makes a difference in the response to antidepressants and that the psychiatrist should not only be seen as a *provider*, but also a *means* of treatment (McKay et al. 2006).

In medicine in general, an approach known as relationship-centred care has been gaining increasing acceptance (Malherbe 2014). Here emphasis is placed on partnership, shared-decision making and attention to the client-practitioner relationship. The core competency of developing a therapeutic relationship is thus again highlighted (Silverstein and Bellack 2008).

One of the important factors associated with good recovery is a collaborative therapeutic alliance (Silverstein and Bellack 2008). This is also echoed by Falkenström et al. (2013). Their analysis of 646 patients in primary care psychotherapy indicated that the alliance predicted subsequent change in symptoms. Results also underline that therapists should pay attention to ruptures and repair of the therapeutic alliance.

Stubbe (2014) identified six factors that contribute to the doctor-patient relationship: patients having a choice of doctor, competence, communication, compassion, continuity of care and no conflict of interest. It is especially important to keep these in mind if the psychiatrist operates within a 'split-treatment' model of care where he or she provides the psychopharmacological care and a non-physician provides the psychotherapy or psychosocial interventions (Stubbe: 2014).

### **8.5.3 Trust**

As part of his psychoanalytic training, Symington (2007) had to do one year of infant observation (observing a mother and her infant on a weekly basis in their home). He writes that he observed only one thing that seemed to him significant in the behaviour of the infant: when the baby had reached the stage of just beginning to walk, he could toddle between the mother and Symington without falling, but when he tried to toddle between two inanimate objects, he always fell. Symington's interpretation is that the source of confidence lies in an act of trust directed towards another person. The baby had confidence to walk if his trustful eye was directed to his mother or to Symington. Trust, he writes, goes to something far deeper in the personality than any surface features. "I can trust someone if what they do or say comes from the heart" (Symington 2007: xix).

A patient is in a similar vulnerable position. To trust a physician means to accept this vulnerability based on positive expectations of the physician's intentions and behaviour. Paediatricians and patients identified trust that developed between paediatrician, children and their parents as the most significant aspect of their interaction (Stein 2011).

Lee and Lin (2011) investigated this by conducting a one-year longitudinal analysis of 614 type two diabetic patients. They found that higher levels of trust were positively related to glycaemic control, physical and mental health-related quality of life and satisfaction after 12 months. Their conclusion is that efforts should be made to cultivate patients' trust and enhance their decision-making preferences.

#### **8.5.4 The particular *place* of therapy or consultations**

Technique and the therapeutic relationship or alliance are topics often discussed in psychotherapeutic practice. Fenner (2011) states that the setting in which psychological therapies occur has however attracted little research attention to date. The setting is a prominent theme in psychoanalysis and psychoanalytic psychotherapy; but there it refers to issues of the 'frame' of therapy such as time, duration and frequency of sessions, fees and seating arrangement, or use of the couch (Gabbard 2010).

What Fenner refers to is the material environment of the encounter. Coming from art therapy, she mulls over aspects of the particular place in which therapy happens and the lived experience of that specific place. "Place is foundational to experience in the same way as the key signature in a musical score anchors all thematic material and subsequent modulations" (Fenner 2011: 852). The room should not be seen as only functional, stable, inert and a mere backdrop to the therapy. It is rather that the room, objects and zones play a role in the meaning-making process. Objects in the room were often loved for "the sheer force" of their being (Mathews 2003: 87), or for their material nature, or the information they communicated. Fenner found that deep attachments to place and to objects and zones in the room provided support and stabilising influences on the therapy process for both patients and therapists. This has implications for the designation of facilities in public and private health domains, especially in the trend of sharing rooms.

### 8.5.5 Social class

Verlinde et al. (2012) note that an essential part of health care delivery is the doctor-patient relationship. For this, the communication skills of the doctor are very important. Doctor-patient communication varies, however, according to the social class of the patient. Lower income populations report lower communication satisfaction. Verlinde et al. found in their review of the social gradient in doctor-patient communication that patients from lower social classes (measured by income, education or occupation) received:

- Less socio-emotional talk
- A more directive and less participatory consulting style characterised by for example less participation in treatment decisions
- A higher percentage of bio-medical talk and physicians' asking questions
- Lower patient control over communication
- Less diagnostic and treatment information.

Doctors give more information, more explanations and more support to patients from a higher socio-economic status; they also adapt more often a shared decision making style. Doctor-patient communication is however, a complex interactional system and patients' style and attitude also play a role. Physicians' information giving was positively influenced by the patient's communicative style, such as question-asking, affective expressiveness and opinion giving. Patients that are more educated are not only more expressive and assertive but they also ask more questions. Lower social class is associated with a lower sense of personal control and an external locus of control. This means that the person perceives that certain events such as health and sickness are beyond his or her control and this might lead to lower levels of participation.

Physicians need to be aware of these differences, listen to patients and encourage patients to engage in a more active way.

On the other hand, it is important not to take patient-centred care as the obvious and only choice. When working patient-centred, physicians should

not only focus on normative thinking regarding participatory decision making but they also have to pay greater attention to a broader set of considerations relating to respect for patients as individuals. It is important to enable and empower patients but it is perhaps even more important to enable and empower them to the degree that they desire (Verlinde et al. 2012).

### **8.5.6 Different models of interacting with patients**

In practising medicine, a physician can operate from within three different models (Charles, Gafni and Whelan 1997; Moreau et al. 2012):

- A paternalistic model, in which the physician decides what is best for the patient.
- A consumerist-informative model, in which the autonomous patient makes a decision after having been informed.
- A shared-decision making model, in which decisions are reached through discussions between physician and patient and where the patient plays an active role in this decision-making process.

Although these models overlap to a certain degree, the shared-decision making model is often considered the ideal approach. A physician, however, needs to be flexible in moving between them, since an elderly patient might for example prefer the paternalistic model. In person-centred psychiatry, such preferences should be noted and respected.

Patients have a huge need for information, regardless of the model. Information exchange by question-response reinforces the therapeutic alliance and allows the patient to develop a better understanding (Moreau et al. 2012). Physicians who are emotionally involved and give more information achieve greater patient involvement (Van den Brink-Muinen et al. 2006).

### **8.5.7 The intercultural and interracial therapeutic relationship**

Psychotherapy can be effective with patients from a wide variety of cultural and racial backgrounds, but there are significant barriers to effective care. The interpersonal relationship is, as with other psychotherapies, considered essential to effective intercultural psychotherapy, but entails considerably more challenges than intercultural or interracial therapy. In their paper, Qureshi and Collazos (2011) include ethnic, religious and racial differences under the rubric of cultural differences.

Cultural factors such as communication style, cultural values and norms, cultural concepts and cultural perspectives on health and healing can cause difficulties in the therapeutic alliance; misunderstandings between patient and therapist can arise if they are not aware of different perspectives regarding their view of the world and the therapeutic process (Qureshi and Collazos 2011). For example, traditional culture systems place God at the centre, modern systems man. Modern health systems expect patients to attend regular scheduled sessions, to be on time and to speak about intimate detail; for a patient from a traditional system this might be extremely difficult. Any deviation of the patient from the norm could be wrongly interpreted by the psychiatrist, e.g. as resistance. Actions such as a patient not saying what he or she really feels, expressing an inappropriate amount of emotion or being evasive might be seen as signs of psychopathology. This could challenge the therapeutic alliance.

In certain cultures, direct expression of emotions is seen as a sign of poor education or rudeness; to criticise someone of equal or superior status is inappropriate and self-disclosure is only done in a certain socially prescribed context. “Say what you mean” typifies Western style of disclosure, the focus is on semantic meaning. In other cultures much more emphasis is placed on non-verbal communication, “one ‘listens’ with one’s eyes; actions, body language and contextual cues ‘speak’ louder than words” (Qureshi and Collazos 2011: 12). Tone of voice, body language and eye contact or the absence thereof will have different meanings and might for example not be an expression of timidity.

Many cultures also do not operate within Cartesian dualism and have a holistic approach. Not accepting the explanatory paradigm of the physician might not be 'poor insight', but the belief in a different explanatory model.

Qureshi and Collazos (2011) describe the following possible problematic counter-transference reactions of the therapist:

- i. Viewing the patient as an 'exotic' other and not as a person in need; the clinician then acts more like an anthropologist.
- ii. Seeing the patient as 'a white man's burden'. This would be a form of racism, where the therapist tries to be helpful, but sees the other culture as inferior.
- iii. Colour blindness I: the importance of race, cultural difference and racism is denied.
- iv. Colour blindness II: the clinician acknowledges the importance of race, but feels that everything is right in his or her office and that he or she is able to see the patient as he 'really' is and not as a racial or cultural being.
- v. The patient as problem: the therapist claims not to be a racist, but thinks that it is some aspect of the patient's racial or ethnic group that is the cause of the patient's distress.

Patients can also have strong transference reactions to their therapists' racial or ethnic group; this can, if unattended, have a negative effect on the alliance, especially since transference reactions are unconscious. A patient of a minority group can, for example, have an unconscious racist view and over- or under evaluate a majority group therapist.

Cultural competence training is thus important to help therapists deal with these issues. Cultural competence comprises three basic domains (Qureshi and Collazos 2011):

- i. **Knowledge:** this is a potentially paradoxical situation, since cultural knowledge can impede the development of a therapeutic relationship, "because contact is not with the patient herself or himself, but rather filtered through the ideas the therapist has gained about the patient's culture". (Qureshi and Collazos 2011: 16). Cultural awareness is important, but the therapist should be wary not to generalise, but to focus on this specific patient.

- ii. **Skills:** flexibility and adaptability are asked from the therapist and not the application of a standard treatment process; the therapist needs to keep in mind the interplay of different cultural values.
- iii. **Attitudes and beliefs:** a willingness to confront personal attitudes and beliefs, with the understanding that there is no correct approach and that erring will be part of the process. It requires a willingness on the clinician's part to explore his or her own racial prejudices, attitudes and beliefs and the understanding that a host of non-therapeutic factors can influence the therapeutic relationship. The therapist should thus step down from the role as expert who applies the correct theory and technique and be open to a new learning experience.

If these factors are not attended to patient and therapist will talk past each other.

Swartz (1998), in writing about the multi-disciplinary team, states that having members of different professions available to patients will not necessarily improve the care. For example, nursing staff who in a specific situation could be culturally more competent may be intimidated and silenced by the presence of a psychologist. In the multi-disciplinary team there is also potential for conflict amongst the different groups; such conflict, states Swartz, "can be a very good thing for patients provided members of different professions have the confidence and power to engage with and influence the view of others" (p. 247).

Some of the problems and areas of importance identified by Swartz (1998) are:

- A lack of mental health professionals in Africa and the need to engage with a variety of resources such as community mental health workers. Training and support of these community health workers is however not easy and needs careful assessment.
- Intersectoral collaboration is important. Swartz refers here to closer collaboration between disciplines focused on either mental or physical health, as these boundaries do not have the same meaning across cultures; furthermore also to collaboration with indigenous healers. "It is also, however, very important not to be romantic about what indigenous healing has to offer. A relationship of respect is not one of simply accepting that a system is effective without interrogating both its strengths and weaknesses ..." (Swartz 1998: 253).

- Interpersonal skills are very important, but it is at least as important to understand what is happening in the interview room and why. It is thus far better to ask directly about cultural beliefs than to conceal ignorance by not asking. At times, however, patients will attempt to mask their problems or block access on the part of the physician by claiming cultural difference as a basis for misunderstanding.
- People have different interpretations about health, illness and wellbeing. This needs to be kept in mind both in working with an individual and in the development of mental health policies.

Swartz (1998: 261) ends by saying that “(u)nderstanding culture and mental health is not so much about knowing about a range of different experiences and practices as it is about having a way to interpret what we see around us”. Thinking culturally is about trying to make sense of what we see and not about applying cultural labels to what we see.

#### **8.5.8 First consultation and frequency of being seen: comments from a psychoanalytic point of view**

The first interview is of great importance. Even before the first meeting, the interviewer is associated with both hope and fear (Wegner 2014). This process already starts with the ‘preliminary phenomena’, such as arranging an appointment on the phone, the choice of words and voice, as well as the analyst’s attitude on the phone. For example, the first meeting, the opening scene and the first verbal communication are all of importance (Wegner 2014). Writing about an analytic setup Wegner states (p. 508): “... unless the patient’s helplessness has reached extreme proportions, he will generally only maintain a therapeutic relationship if he feels adequately understood by the analyst’s attitude and intervention”.

Psychoanalysis, measured in years, is an intense undertaking for both analyst and patient. The assessment of whom to take into analysis is therefore important. It is a decision of whether the analyst is willing to assume responsibility for a particular patient (Wegner 2014). Yet Wegner (2014: 513) writes: “There is considerable evidence that such decisions are made – more or less consciously – very quickly.” He does not elaborate on

how long ‘very quickly’ is, but the message is that patient and therapist quickly sum each other up.

Recent investigations in psychoanalytic thinking seek to understand how long after the conclusion of one session and the start of the next constructive or destructive processes gain ground in the patient, and what significance this may have on the treatment that follows. A positive inner process, a process in which some inner work is being done by the patient in between sessions, is termed *self-efficacy*. A negative process, “a self-recombining pathological self-organization” (Wegner 2014: 515) may however also start in the patient.

“Where little or no self-efficacy emerges in a patient between sessions, it can be assumed, for instance, that psychoanalytically orientated psychotherapeutic work in the low-frequency setting is not appropriate for the patient” (Wegner 2014: 516). More frequent sessions therefore need to be organised if this is the case.

## **Summary**

In summary, there is thus ample evidence of the importance of good and secure relationships. According to Priebe, Burns and Craig (2013) even the most hardened sceptic has to acknowledge that there is abundant evidence of the importance of personal relationships in shaping both cause and cure of disorders.

## **8.6 TRAINING OF PSYCHIATRIC REGISTRARS**

### **8.6.1 Some general comments on training**

Criticism has been levelled at the culture of care - or lack thereof - instilled by medical education (Parker and Leggett 2012). There is some evidence that the level of empathy tends to decline in later years of medical school and the early post-graduate years (Bellini, Baime and Shea 2002; Bellini and Shea 2005; Nunes et al. 2011). In Bellini and Shea’s study (2005) of 61 residents during their internal medicine residency training, a challenging training with long working hours, sleep loss and significant personal compromises, common mood disturbances were seen. The good news of their study was that personal

distress improved over the years of training. The bad news however was that the empathic concern, on which residents initially scored high, decreased, remained low and never recovered. They conclude (Bellini and Shea 2005: 167): “Among the many challenges ahead for medical education, protecting the development of empathy during times of immense change will certainly be one of them”.

The decline in empathy is however disputed. Colliver et al. (2010) write that re-examination of the research shows only a weak decline in mean ratings and that even this result is questionable.

A key principle in the delivery of mental health services is to support patients in their personal recovery and to promote wellbeing. According to Stratford, Brophy and Castle (2012) this requires psychiatrists to develop or to return to a worldview that promotes a hopeful stance and acknowledges the importance of relationships when working with people experiencing mental ill health. To support a person’s mental health recovery, a strong and supportive relationship that encourages hope must exist (Meehan et al. 2008). If a doctor wants to understand his patient and not treat him as a thing, he must, according to the psychoanalyst and philosopher Fromm (1963), learn another attitude apart from the scientific attitude in which he was trained: how to relate as one human being to another. Unless this is done, he writes, all slogans about the patient as a person will just be empty talk.

Training in psychotherapy, which involves interpersonal skills and has as focus the therapeutic relationship, is thus of great importance in registrar training. In training, attention needs to be drawn to non-specific common factors that account for, according to certain researchers, almost all change in psychotherapy (Høglend 2014). These are factors like patient expectancy, alliance and therapist empathy. (Specific skills also need to be addressed, but this falls outside the scope of this research.)

Gabbard (2005) writes that a contemporary psychotherapy teacher needs to convey to psychiatric residents that psychotherapeutic principles should be applied in all settings where treatment is delivered. He also emphasises that psychiatrists, and not psychologists, need to train registrars in psychotherapy, since one learns mainly from

example, the example of having a consultant psychiatrist doing and teaching psychotherapy.

### 8.6.2 Mentoring needs

Brown et al. (2012) collected data on mentoring from 49 students and 29 family practice residents. Trainees' specific learning needs, to be addressed by mentors, were identified and categorised on three levels:

- i. **Practice level:** guidance regarding the logistics of practice management.
- ii. **System level:** knowledge about the medical community and the community resources.
- iii. **Personal level:** guidance in balancing personal and professional responsibilities.

Choice was important in having a successful mentoring relationship. Respect and a wish to emulate the mentor was important, as well as continuity with a mentor over the years of residency. Participants described the various roles of the mentor as being a sounding board, coach, teacher, role model and advisor. Multiple mentors were often sought out to fulfil various needs at different points during their career. Attributes of a good mentor were being approachable, a good listener and demonstrating passion and commitment to their work. A critical factor was observing the patient-doctor/mentor relationship and wanting to emulate a similar patient-doctor relationship in the future.

### 8.6.3 Balint groups

Balint groups, as a training opportunity, were started by the psychoanalysts Michael and Enid Balint in London in the 1950's (Balint 1985; Mahoney et al. 2013). Nowadays, Balint training is used in the United States in residency programmes associated with family medicine, psychiatry, paediatrics, obstetrics and gynaecology and internal medicine. About half of family medicine residency programs in the United States conduct Balint groups as part of their curriculum (Mahoney et al. 2013).

The purpose of Balint training is to study the doctor-patient relationship in a group setting with the expectation that the therapeutic potential of relationships can be revealed and explored through the cultivation of empathy. Groups have between 4 and 10 members, and meet every 1 to 4 weeks for 1 to 3 years. In the group seminar, a resident presents a “troubling patient” from memory while the group listens without interruption until the presentation is complete. (Mahoney et al. 2013: 402)

The goal is to understand the issue from both the patient’s and doctor’s perspectives rather than find specific solutions to the problem at hand. It is not a support group, but rather an effort to understand the problems in that particular doctor-patient interaction.

Balint work is based on identification and understanding. An observer must first identify himself with someone, then he must withdraw from that identification and become an objective, professional observer. The doctor “holds on to feelings which a patient has put into him, and with which for a short time he totally identifies with but which he is then able to distance himself from” (Balint 1985: 8). Mahoney et al. (2013) understand this to be the empathic process.

Balint group cases often reflect the presenting resident’s trouble staying in the role of physician and fulfilling those role expectations. In his professional role, the physician is expected to determine the reason for the visit and to implement a management plan based on best practices. A physician may however find himself deflected into the role of a nurturer or rescuer.

Thus, it has been argued that staying in the role of physician in the face of deflections (over-identification) and distractions (under-identification) is the professional responsibility of a competent physician. The acquisition of this skill lies at the essence of Balint training in making better doctors. (Mahoney et al. 2013: 404)

Balint groups aim to help providers recognize their blind spots and transferences, helping them to better understand their reactions to difficult

patients. It is this self-illumination that makes them better doctors, enabling them to be more authentic in the doctor's role. (Mahoney et al. 2013: 409)

Reported benefits of Balint groups are an improvement in self-concept as a physician, expressed as an improvement in confidence, comfort, professional self-esteem or competence in the patient encounter. Difficult patients were less of a burden and physicians felt less resentment towards patients (Mahoney et al. 2013).

#### **8.6.4 What attention should the registrar's personal characteristics and mental health receive?**

More and more studies on empathy and its effect on the patient-doctor relationship are being published. However, there is a shortage of studies focussing on other physician factors, such as his or her beliefs, personal satisfaction with his or her profession, his or her values and personal life and the association of these factors with patient outcomes (Gómez and Aillach 2013). These are interesting and important factors for further research. How does the physician's personal satisfaction influence patient outcome? Does this satisfaction change over the years? What might lead to change?

There are many hindrances to the development of therapeutic relationships, for example the focus on biological aspects of psychiatric illness and the loss of 'mind' (Reiser 1988; Mintz and Flynn 2012), a high patient load and the demands placed on registrars by the curriculum, which includes many examinations, post-graduate discussions and a research project. Registrars' lack of interest in understanding the patient as person can also form an obstacle to establishing such therapeutic relationships (Reiser 1988). However, maybe one of the most important factors is an anxiety about this relatively unknown field of interpersonal relations, as described by two senior British registrars (Paul and Bluck 1997). This might partly be the reason for an apparent lack of interest shown at times.

Another considerable hindrance is that in this type of work, knowledge alone is not enough, it also depends on the maturity and wisdom of the therapist or doctor. Rogers (1961) writes that the degree to which I can create relationships, which facilitate the growth

of others as separate persons, is a measure of the growth I have achieved in myself; a challenging thought.

Nissen-Lie et al. (2013) did research on how personal experiences and the quality of therapists' personal life influence the working alliance. Personal satisfaction and personal burdens were assessed and investigated as predictors of alliance levels and growth (Nissen-Lie et al. 2013). Their study supported previous investigations, demonstrating that therapists differ considerably in their ability to foster a working alliance with their patients and that psychotherapists' quality of life influenced the way in which they related to their patients. They echo Rogers (1961) in stating that a therapist's personal life quality influences his or her emotional reserves and capacity to attune to their patients. "...therapists' perception of social support and quality of their private life relationships were positively associated with their patients' alliance evaluations, whereas professional factors were not" (Nissen-Lie et al. 2013: 490).

Originally, very different schools of therapy emphasised therapeutic technique over the therapeutic relationship and the contribution of the therapist as an individual to promoting change (Gelso and Hayes 2007; Nissen-Lie et al. 2013). This somewhat out-dated model does not take into account the mutuality of psychotherapy exchanges and the influence of the therapist's personality, interpersonal style and even personal life (Norcross and Lambert 2011).

Therapists' reports of personal conflicts and burdens had little effect on their own alliance ratings, but these experiences were strongly and inversely related to alliance development over time when the alliance was rated by their patients (Nissen-Lie et al. 2013). Therapists rated a satisfying private life high, but this factor had little bearing on the evaluation done by the patients. The researchers identified three possible issues to help explain this discrepancy:

- i. Therapists who feel more satisfied might be predisposed to perceive the alliance in a more positive light, not realising that their ability to form better alliances may not actually improve.

- ii. Patients seem to be particularly sensitive to their therapists' private life experience of distress, which presumably is communicated through the therapists' behaviour in the sessions. Even subtle signs of disinterest, rejection, aggression or defensive behaviours may result from increased burdens in the therapist's life and this may lead to deterioration in the alliance.
- iii. The alliances of therapists who felt more burdened by their private life did not improve as much as those of therapists who felt less burdened. These burdens may contribute to a more negative countertransference, leading to under- or over involvement, and a worsening of the alliance.

According to Nissen-Lie et al. (2013: 419), their research "suggests that, when the alliance is rated by the patients, the most important sources of influence from the therapists' quality of life are those that are negative in valence, rather than positive." It seems that patients are much more attuned to a therapist's negative emotional state.

The term 'countertransference' was coined by Freud (1910). Emotions, complexes and resistances in the therapist may hinder his or her work as therapist and Freud recommended further psychoanalysis for the analysts themselves in such situations. Today, how to define, understand and use countertransference remains one of the core discussions in psychoanalytic writings (Gaddard 2005b; 2010). Therapists who are better able to manage negative countertransference seem to be able to form a better working alliance. Over- or under involvement due to unresolved countertransference issues also affects the working alliance in a negative way (Nissen-Lie et al. 2013).

In summary, it seems that therapists who are less burdened in their personal lives are able to build better alliances and become more capable to deal with their patients' needs. Personal characteristics seem to be more important than therapists' professional qualifications in determining their therapeutic capabilities (Nissen-Lie et al. 2013).

Heinonen et al. (2014) studied the difference between therapists conducting psychoanalysis vs. those conducting long-term psychodynamic psychotherapy (LTPP). Previous studies quoted by them showed that therapists who scored low on kindness, self-disclosure and supportiveness (seen by some as classically psychoanalytic attitudes),

were ineffective when conducting LTPP (Sandell et al. 2000; Grant and Sandell 2004). Therapist qualities stemming from private life might however also matter. Blatt and Shahar (2004) note that therapists' attachment style may influence their professional way of relating and consequently the treatment process.

In their study of 367 patients in the Helsinki region, Heinonen et al. (2014) found that being less affirming (i.e. less 'accepting', 'friendly', 'tolerant' and 'warm') predicted a relatively high symptom level in LPP throughout the five year follow-up and that therapists low on kindness and supportiveness were especially unbeneficial in LPP.

Wegner (2014) writes that more research needs to be done on the psychoanalyst's anxieties about the psychoanalytic method, because these anxieties can obstruct the beginning of psychoanalysis. He refers here to the fear of unconscious processes in both the patient and the analyst. He also states that a new patient can cause anxieties in the analyst and quotes Rosenfeld who said that "(t)he most common blockages in the patient-analyst interaction relate to the analyst's early childhood anxieties" (Rosenfeld 1987: 40). Rosenfeld refers to how unresolved psychological problems in the treater can impact on the therapeutic relationship. Similar anxieties, related to the registrar's emotional problems, will also play a role in registrar-patient interaction.

The first step in becoming a psychoanalyst is to undergo psychoanalysis oneself. Neville Symington (2007) writes that the three analysts who interviewed him before he was accepted for training did not see past the impressive façade to the sick man behind it. His training analyst however did see past that façade and insisted on analysis *before* he started his training. Only after three and a half years of psychoanalysis did he enter the training programme. Symington, nowadays an internationally known and respected psychoanalyst and writer, says it was a great relief when his training analyst realised the extent of his emotional problems and was frank with him about it.

It is therefore about more than the registrar's personal characteristics; it is also about his or her (and our) mental health and maturity, as stated by Rogers.

Symington (2007) takes the concept of personal development further. He asks what and who is a person. His answer is that “a person is someone who has actively taken possession of all parts of himself” and who is in relation to the other (Symington 2007: 299). The human person is a creation; someone has made a choice about himself and his life, a choice to create a unified pattern out of disparate fragments. There is thus an organising centre. Not all people are persons; some stay a ‘someone’, that is an un-integrated individual where parts of him or her have been disowned or split off, with projection of these parts into others. This is not only known to psychoanalysts. Hesse in his book *Steppenwolf* (1955: 15) writes about the Steppenwolf: “...the illness of this sufferer did not rest on some deficiency of his nature, but on the contrary only on the ‘unintegration’ of the great abundance of his talents and powers with a resultant lack of harmony” (my translation). And Bamm (1968: 84) says that to be called an ‘individuum’ is in Bavaria close to an insult. An ‘individuum’, he writes, is only ‘put together’, it has no centre, no destiny and with that also no dignity. And yes, he states, there are such people.

Symington (2007) writes that a person comes into being through a relationship with a person. In this, he follows Buber who stated (1984: 32): “Der Mensch wird am Du zum Ich” (A person comes into being by relating to another person). Our task is to create a person out of all the raw material. First of ourselves, and then to help the other. The Steppenwolf in Hesse’s book (1955) did not achieve this; we might also not.

## **8.6.5 What needs attention? A few central aspects**

### **8.6.5.1 Being present, listening, explaining**

“The pressures of the healthcare system have pushed residents in training to learn to manage their patients rather than listen to them” (Shapiro 2012: 204). In contemporary psychiatry, the emphasis is on the correct DSM diagnosis; little time is left for reflection and to try and understand whether there is anything meaningful in the patient’s symptoms. “Our obligation is to teach our trainees ... to listen to and understand their patients’ struggles” (Shapiro 2012: 204). When a patient shows up, they want someone to listen to them; they want to tell us something that they may not be able to say directly, but their interpersonal behaviour might affect us negatively. The clinician’s job is to translate their

communication, to enable the clinician and the patient to make use of it. Shapiro wonders whether the inability to listen to patients contribute to the problem of treatment resistance.

Physicians who demonstrate attentive and respectful listening reinforce the healing process and may contribute to improved clinical outcomes (Jagosh et al. 2011). These researchers furthermore found that patients described listening, a defining feature of a 'good' doctor, as fulfilling three functions:

- It enables physicians to make accurate diagnoses
- It is instrumental in creating and maintaining a good doctor-patient relationship
- It acts as a healing and therapeutic agent.

Rodenburg, one of the world's leading voice and acting coaches, writes that people believe 'presence' is something you have or do not have (Rodenburg 2008). She does not agree: "... you can learn to find your own charisma. All it is, is energy. Present energy – clear, whole and attentive energy" (p. xi). She writes that babies and toddlers, great communicators, great healers and spiritual teachers are present, almost constantly. "Presence is the energy that comes from you and connects you to the outside world. ... It is when you are fully present that you do your best work and make your deepest impression" (p. 11). Her book is about finding your presence and living with full presence; another course that overworked registrars could take!

The University of Colorado, School of Medicine, introduced a course for teaching communication skills emphasising techniques of open-ended inquiry, empathy and engagement to gather data (Boyle, Dwinnell and Platt 2005). The method, referred to as ILS (Invite, Listen and Summarise) was developed to combat the high-physician control interview techniques, characterised by a series of 'yes' or 'no' answers. This reflects the realisation of the importance of patient-centred communication skills (Boyle et al. 2005).

If the physician is not able to listen, if bearing with what the patient brings is too much, a management response, e.g. mobilising social services is used to deal with the reactive feelings of the physician (Shapiro 2012). There is no attempt to understand what is

happening. Important is that this is also linked to the culture in the specific treatment facility.

### **8.6.5.2 Reflecting on the treatment facility**

Each treatment facility is a dynamic system with its own unique frame and common culture (Shapiro 2012). Too many needs and too few resources can put pressure on all staff members, causing difficult feelings to bear with, and suppression or acting out of such feelings. This will interfere with the work. Running seminar groups with a “focus on listening can offer a new training culture to a pressured clinical system otherwise focussed on management” (Shapiro 2012: 206). A change in attitude opens up the possibility of a different form of intervention.

Registrars working in pressured systems have to find ways to deal with the situation. One way of dealing with it is to hate the system they are in and to blame it for the different problems, such as their own feelings or the limitations in care. The institution becomes a garbage dump for all the unexamined negative countertransference experiences of the staff. Shapiro asks (2012: 206): “If you hate your organization or have contempt for it, how do you manage your self-esteem for continuing to work within it?” It leads to feelings of hopelessness, more management techniques and less engaging with and making sense of the painful life experiences of patients.

What is required is the identification with a mission and a set of values that link colleagues to something beyond themselves, as well as a reflective space to identify, detoxify and put into perspective the difficulties the institution faces.

Shapiro (2012) thus points towards the need to provide containment for the most vulnerable staff members, which includes overworked registrars.

### 8.6.5.3 Including psychoanalytic concepts, skill and attitudes in teaching

Academic psychiatry is divided about the teaching of psychodynamics in psychiatry. (The terms psychodynamic and psychoanalytic are used interchangeably by many, e.g. Shedler 2010.) Psychodynamic ideas are largely neglected due to the dearth of psychoanalytic teachers and the reification of psychopharmacology and DSM diagnostic skills. The costs to students is however considerable, “as a psychoanalytic perspective offers an important antidote to dehumanising pressures that reduce psychiatry to the interaction between a drug and a neurotransmitter receptor” (Mintz 2013: 752).

To teach medical students only a biologically reductionistic model of psychiatric treatment fails to educate them about the richness and complexity of our heritage, leaves students with a serious misconception about the (possible) nature of psychiatric practice and dovetails “with the increasingly common stereotype of the psychiatrist as an impersonal and unreflective pill-pusher” (Mintz 2013: 753).

An education in psychodynamic thinking need not be seen as training students to be psychotherapists, but to help them think in a different and holistic way about a patient. Psychodynamic understanding may furthermore be well suited for fostering empathy in students (Mintz 2013). Treloar (2009) studied the impact of two types of education programs (cognitive-behavioural and psychoanalytic) on clinicians' attitude toward deliberate self-harm behaviours of patients with borderline personality disorder and toward working with these patients. Having a formulation that explained difficult behaviour promoted empathy in health care providers. At six-month follow-up, she found that only in the psychoanalytic education group these benefits were significantly maintained.

According to Shedler (2010) the available evidence indicates that the ‘active ingredients’ of other psychotherapies include techniques and processes that have long been core and centrally defining features of psychodynamic treatment.

Transference and countertransference are two of the core concepts of psychoanalytic theory and therapy that have become part of psychiatry. Transference means that a

person unconsciously re-enacts relationships of the past instead of remembering them (Gabbard 2005b). Qualities of a relationship with a figure from the patient's past are, for example, attributed to the psychiatrist. Countertransference is similar to transference and is regarded as the therapist's total emotional reaction to the patient (Gabbard 2010). In a more detailed definition Gabbard (2005b: 21) describes countertransference "as entailing a jointly created reaction in the clinician that stems in part from contributions of the clinician's past and in part from feelings induced by the patient's behaviour". This expanded definition acknowledges the patient's contribution to countertransference, a concept that nowadays is "considered a major therapeutic and diagnostic tool that tells the therapist a great deal about the patient's internal world" (Gabbard 2010: 15).

In any psychiatric practice, it is of utmost importance to attend to, understand and manage countertransference. Neglecting this places the therapist at risk of acting out these unresolved conflicts, endangering the therapy (Gelso et al. 2002). In their study of 32 therapist-trainees and their clinical supervisors, Gelso et al. found support for the hypothesis that countertransference management correlated positively with client outcome. The better trainee-therapists were able to manage their countertransference; the better was the outcome of brief therapies. Self-integration (the recognition and maintaining of appropriate boundaries between therapist and patient), anxiety management and conceptualisation skills were significantly correlated with outcome.

Another valuable concept coming from psychoanalysis is that of the setting or frame.

The analytic setting or frame is generally thought to include the establishment and maintenance of the physical setting and of the psychoanalytic contract, which includes negotiation of the time, frequency of sessions, use of the couch and money, and the role of the analyst ...Many would also include the analyst's internal setting, that is, the setting as a structure in the mind of the analyst... (Lemma 2014: 225)

The frame also includes the location and duration of the sessions, the absence of physical contact, payment for the service and limited self-disclosure on the side of the analyst (Gabbard 2010). The function of the frame or setting is to be the essential 'background'

that provides the necessary containment of the patient and allows the unfolding of the therapeutic process. “(T)he role of the analyst is to be the custodian of the setting” (Lemma 2014: 226). Amongst other things, the analyst will pay attention to how the patient reacts to the setting.

Gabbard (2010) writes that the frame should not be seen as something like an inflexible picture frame, but that the flexible ropes of a boxing ring might be a better image (although, he writes, the analogy with boxing is problematic). The frame consists of boundaries that “are designed to create an envelope within which the therapist can be empathic, warm, and responsive and to establish a holding environment where the patient feels understood and validated” (Gabbard 2010: 60). The boundaries create a safe and secure context and space.

Keeping the setting is already a major therapeutic aspect of psychoanalytic psychotherapy. During my more than four years of weekly supervision, my supervisor often said: “Keep the setting and with many patients the psychotherapy will just flow”.

Another extremely important concept, already discussed in Section 8.4.7, is that of containment through a personal relationship. Registrars need to be familiar with this concept and need to work on their skills to provide such a form of containment.

#### **8.6.5.4 The need for on-going professional development**

In a qualitative enquiry of 12 psychotherapists with an average age of 74, Rønnestad and Skovholt (2001) identified two aspects important for training:

- i. Professional growth is affected by experiences in both professional and personal life. Education never stops. For these therapists the years after graduation were rich in educating them about professional issues and about life. But, in spite of on-going personal and professional influences, the participants were still very much influenced by early life experiences. It is thus important to continually process and reflect upon the ways that childhood experiences may affect professional

development and functioning. Mentoring relationships were furthermore important throughout their life.

- ii. The processing of profound experiences is important for a high level of functioning. The classic saying that one can have 20 years of experience, or 20 times doing the same every year captures the challenge of transforming experience into wisdom. To do this it is important to reflect upon and process potentially rich experiences; classic ways of doing this are one's own personal therapy, supervision or consultation. Peer-group supervision or seminars on practitioner topics can also be helpful. For personal development, reflection in various ways is of paramount importance. The fact that personal life is an important arena for professional development is often overlooked.

## **8.7 LINKING THE LITERATURE REVIEW WITH THE REST OF THE STUDY**

In planning the literature review, I thought about the experiences of the patients in this study, linking it with my knowledge about psychotherapy and relationships.

I therefore attended to prominent aspects of health care and developments of models of care, for example the biopsychosocial-spiritual approach. I also sketched some of the pressing problems encountered in the care of psychiatric patients. Then, coming from person-centred care, I thought about various aspects of relationships, first in general and then about the therapeutic relationship.

Lastly, I focussed on a few important areas in the training of registrars, also on areas usually less addressed, such as a registrar's personal characteristics and mental health.

## **9 AN ANALYSIS OF THE CARE AND TREATMENT OFFERED AT WESKOPPIES PSYCHIATRIC HOSPITAL, LEADING TO THE DEVELOPMENT OF A MODEL AND SUBSTANTIVE THEORY OF THERAPEUTIC RELATIONSHIPS**

### **9.1 INTRODUCTION**

This chapter is a pulling together of the information gathered through the interviews and the literature review. It is furthermore my effort to integrate this information with my previous experience and my points of view, to therefore paint a picture of what is happening at present in the hospital, to analyse these happenings and to develop a model and substantive theory of therapeutic relationships.

From discussing the various types of encounters in the hospital, I carry on to discuss the topic of containment, then a scrutiny of the MDT follows. This approach is not haphazard, since a therapeutic relationship is built on these foundations. The seventh model, which I discuss, is a representation of this structure. I also analyse obstacles in the way of developing such relationships. In Chapter 11, I attend to implications and recommendations flowing from this model.

I start however with a summary made when I re-read all the transcriptions of the interviews about one year after the initial readings of the transcriptions.

**Table 9: Summary of the most salient findings with each participant**

Abbreviations used: NS: Nursing staff;  
 Pt no: Patient number  
 SW: Social worker  
 TR: Therapeutic relationship

Pt no	Positive experiences	Negative experiences	Therapeutic relationship	Theoretical notes, or: What did I learn? (Most salient aspects.)
1	Very relieved to be in open ward after a lengthy stint in a closed ward. God heals.	Closed ward: Felt powerless, helpless; MDT has the say. Doctors don't have time and not enough "rights". "There is one big mistake in WKH: They treat all the same." (No attention to a patient's unique history.) "You are only a number."	Fairly good relationship with 2 patients and 2 NS-members.	Very positive change only two days after first interview because of move to an open ward. Would want to follow up with SW because she knows him and family. He was so glad to see me and just talk to me; really missed a therapeutic relationship.
2	Medication heals. Activity at OT very helpful.	Nothing.	None.	Just being "nice" to patients is so important.
3	To escape from outside stressors. Peaceful environment.	Nothing.	None. Superficial encounters with NS, nonetheless meaningful.	Sharing problems with <i>any</i> staff member is helpful. Catharsis.
4	Fellow patients important and meaningful. Trainee NS treated them as "normal". Looked happy when I saw him in an open ward.	Closed ward: locked up for so many hours is terrible. Not knowing the time. Lost, helpless. "At the mercy of our doctors." Doctors don't have enough time and neglect spiritual realm; his religious conflicts were not addressed. Not having TR "blocked me from growing".	Fellow patients became <i>very</i> important. Also important interaction with trainee NS. Otherwise superficial interactions.	Knowing the time provides <b>containment</b> . Also knowing when your doctor will see you again. Locked up is terrible. To feel "at the mercy of our doctors". Big change after move to an open ward, very relieved.
5	Being able to talk to a nursing sister. A hug can mean so much.	Very upset about difficult fellow patient. Experience of being in a closed ward, locked up and observing other patients being hit by	Superficial relations to NS, nonetheless meaningful. Fellow patients important.	Junior psychologist unable to <b>contain</b> situation led to long time in a closed ward. Important is being humane and not treating patients as numbers. Patient can't <b>contain</b>

Pt no	Positive experiences	Negative experiences	Therapeutic relationship	Theoretical notes, or: What did I learn? (Most salient aspects.)
		staff members was very difficult. Two sides to her lack of trust: her inner conflicts and our letting her down.		feelings – availability of NS so important because just talking helps.
6	Interactions especially with registrar, but also OT and medical student. Enjoyed surroundings.	First doctor's body language negative, it was as if she was bored. Did not know what was going to happen in the first week in WKH, not seen or informed.	Very good with registrar.	Important is being listened to and seen as a unique individual, thus not only a number. Patients have to be seen and informed about programme soon after admission. Group discussions helpful.
7	Fellow patients important, as well as some NS members.	Negative about most aspects of treatment in WKH as well as in 2 private psychiatric hospitals. Not trusting NS – “everything is written down”. Closed ward “was hell”, patients and NS hitting each other, no privacy.	With registrar, although still very limited. Missed a better interaction. Later said fellow patient was most important.	A good doctor is one who listens. An attitude of respect and listening is important. Daily structured routine can be very helpful. Describes NS as, at times, not able to <b>contain</b> the situation in the ward, leading to verbal arguments between NS and patients.
8	Sharing the word of God. Talking to fellow patients and some of the nursing staff.	Difficult patient because she still suffers from psychotic symptoms. Was seen by 7 (!) doctors in 3 months. Says spiritual aspects were not addressed.	Superficial interaction with fellow patients.	NS in closed ward struggling to <b>contain</b> the situation. Rotation of registrars can be very problematic. She expressed the wish that one doctor, who is interested in your history, should look after you.
9	Hospital a shelter, no other place to stay. God helps.	Beaten by staff in closed ward; describes staff as “quite violent”.	None; it does not matter.	Hospital a shelter. Again a story of nursing staff not coping and then becoming violent. Another story about lack of <b>containment</b> .
10	Medication helps.	Two months in closed ward were difficult, not being able to go out.	None. The doctors have “a job” to do.	Being “nice” and friendly towards him was important.
11	Medication and support from family and church members helped.	Having been in a closed ward for four months was stressful. Described follow-up	Fellow patient closest. Later did say a nursing sister became important.	Again someone who was kept for a long time in a closed ward. Were four months necessary?

Pt no	Positive experiences	Negative experiences	Therapeutic relationship	Theoretical notes, or: What did I learn? (Most salient aspects.)
		visits by registrar as very short: "We didn't really talk about anything."		The nursing sister was "a good listener" and was also supportive.
12	Felt comfortable with her private psychiatrist who saw her for 3 years, a woman who was very understanding and who listened well. One to one better.	Five months in hospital. Initially admitted to a closed ward because of a relapse. Saw 6 doctors during time in hospital. (Plus five doctors as an outpatient.) Feels cornered, helpless, imprisoned. NS in closed wards hitting or kicking patients. (Again a lack of <b>containment</b> .) Does not trust NS, because of them "telling confidential issues" to others.	Fellow patient as well as a cleaner became fairly important (same language, similar experiences).	The importance of feeling lonely; such feelings not <b>contained</b> might lead to sexual relations with fellow patients. Also the importance of language, as well as being able to share suffering. Once a week consultations not enough, waiting a week for feedback. A doctor must know you personally, otherwise they'll miss (early) signs of a relapse. Five doctors in hospital! Registrars "can't make decisions by themselves".
13	To be transferred to an open ward and be able to play piano. To be of help to other patients.	The patient described each admission as a crisis "because you are locked up". She described also racial conflict in the wards and tension between patients, especially with those who had a relapse. Closed wards and being locked up, especially in seclusion, were "hell". Another problem is that everyone is afraid of a psychotic patient and she had had several psychotic episodes.	Fellow patient.	Interaction between herself and registrar made more difficult because of medical students being present. Her interaction with the registrars was then positive when she was stable. (Indicates again a problem around providing <b>containment</b> when she is not well.) After having been a patient of WKH for 24 years she says the best registrars are those who show an interest in you and have a certain positive, accepting attitude; who radiate a positive vibe of acceptance. Then a therapeutic relationship can happen immediately.
14	Had a lot of respect for a sister who could handle conflict and	Described tension between NS and patients, also racial	Pastor and also a fellow patient. Also a good inter-action	Nursing sister able to <b>contain</b> through boundaries. Same comment

Pt no	Positive experiences	Negative experiences	Therapeutic relationship	Theoretical notes, or: What did I learn? (Most salient aspects.)
	lay down boundaries to all patients. Pastoral care. Humaneness of registrar.	conflict.	with her registrar. Described pastor and registrar as very friendly, kind-hearted.	as previous patient about medical students being present at consultations. She described pastor and registrar as very professional, as people who had a certain authority.
15	Positive feedback from various people in WKH, even from a driver of WKH. Enjoyed walking on the big terrain.	Admission process very slow. Saw registrar for the first time in her second week in WKH. The previous time "I was also just maybe a number".	Very good with registrar, a nursing sister and fellow patients.	The registrar "has been with me on this road...She knows my history ...she is accommodating and she listens". A friendly, caring and understanding attitude is of great importance. Psycho-education also important.

## 9.2 ENCOUNTERS IN THE HOSPITAL

There are many different types of encounters in a hospital. I have divided them into superficial, negative and meaningful encounters. Superficial encounters are not damaging and might at times even be meaningful. Negative encounters are damaging and need to be minimised. Fortunately, there are also many meaningful encounters.

### 9.2.1 Superficial encounters

Thomas et al. (2002) found that interactions between professional staff and patients were often superficial. Several patients in my study reiterated this – interactions with nursing staff were often described as superficial. In the same vein, Mullen (2009) notes that in nursing care a trend has developed towards observing and monitoring patients; he calls this an "observation culture" (p. 84). One participant in my research complained that nursing staff were excessive in how much they wrote down - everything patients did was recorded; whether they cried, slept, were emotional or suffered from poor appetite.<sup>18</sup> This might have been part of routine observations that have to be done, but it could also fit in

<sup>18</sup> See Section 5.1.2.2.

with Mullen's description. While going through the files of patients I did become aware of the extensive notes made by nursing staff three to four times per day.

So often, when I interact with nursing staff, I experience them as helpful and friendly. Why then such complaints by patients? The one seemingly obvious reason is that working with patients suffering from severe mental illness, and especially in our difficult situation, is very stressful. It can lead to burnout and many negative feelings towards patients. In my second and third year as a consultant in Weskoppies Hospital - 2011 and 2012 - I organised a course for nursing staff on the management of patients with borderline personality disorders, since we have many such patients on our ward. A young, enthusiastic psychologist joined me and put in a lot of effort, showing for example many interesting video clips. Each course consisted of weekly sessions for a total course duration of about four to five months. We started each year with about 30 – 35 participants, but the number dwindled to about five participants at the end of each course. Why? Was it too much for the nursing staff? Did they feel overloaded? Was the standard too high? Were they suffering from burnout and, because of that, not interested in something they experienced as just another demand, or just another attempt to help patients who in any case are so difficult to manage that one would rather see them be discharged? My suspicion is that many do not feel competent enough to engage with patients on a more personal level, that they do not trust their ability to contribute something worthwhile. I discussed this again a few days ago with the Director of Nursing. She confirmed some of my suspicions and told me that nursing staff nowadays receive less training in psychiatry during their years of formal training, contributing to them doubting their own abilities and questioning what they have to offer; training presentations can then at times be of too high a standard.<sup>19</sup>

Swartz (1998) writes that having members of different professions available to patients will not necessarily improve the care. Certain members may feel intimidated by 'experts' in the team and not voice their opinion. I think nursing staff do not always realise how important their role is or can be; this then blocks them from becoming creative in whatever they can offer the patients. They leave it to the 'experts', e.g. the psychologists.

---

<sup>19</sup> Today, the 19<sup>th</sup> of February 2015, three years after presenting these courses, a nursing staff member phoned me, saying that he had resigned, but he wanted to thank me and the psychologist for, amongst other things, those two courses.

However, it would be very helpful if nursing staff could help patients to better cope with their feelings. Patients very often find it difficult to bear with their intense feelings. This is very understandable, since this is why many, perhaps most, have been admitted. To then have to wait for a couple of days until they are seen by a registrar or psychologist can be too much. This was echoed by a patient who said that she would rather talk to a nursing sister who was immediately available, than to wait a couple of days for the registrar. The important role that nursing staff can play, the potential therapeutic alliance between them and the patients, is underlined by such a comment. If the interaction with the registrar is not meaningful, if there is no depth in their interaction, it will lead to patients rather discussing their problems with nursing staff. Why should one wait for someone, for a registrar, who has only a few minutes of time and who might only focus on symptoms and medication?

The four-monthly, frequent rotations of the registrars contribute to superficial encounters. One patient, in three months as an inpatient, had seen seven doctors!<sup>20</sup> In the end, you don't know who your doctor is. This is fortunately not the norm; this specific situation was most probably due to registrars writing examinations. However, even if this was the case, it is not really an excuse; better arrangements could have been made. That this could happen does say that the treating registrar did not think what such an experience would mean to a patient; the patient was not considered.

Having said that the above-mentioned experience is not the norm, I again checked the file of another patient (participant number 12). I have already mentioned in the findings how many doctors this patient had seen. Now I asked myself: Could it really be? Have I somehow made a mistake? However, unfortunately, I was right. According to the notes in her file she was seen, from her admission on the 17<sup>th</sup> of December 2013 until her discharge in January 2014, by Dr. L (in central admissions), Dr. W (once, on call), Dr. H (intern in the team), Dr. S and Dr. Y (intern). After discharge, she was followed up at the outpatient department until the 12<sup>th</sup> of August 2014, when she was referred back to a private psychiatrist. In this time she was seen at WKH by Dr. M, Dr. N, Dr. T, Dr. P and Dr. V (intern). In eight months, she had seen ten doctors. (This patient also mentioned Dr. D as one of her doctors when she was an inpatient, which would make it eleven doctors.)

---

<sup>20</sup> See Section 5.2.4.3 (8<sup>th</sup> participant).

Surely, only very superficial encounters are possible in such circumstances. Interesting, or rather disturbingly, is that this is the same patient who suffered in the hospital from near unbearable feelings of loneliness and who feared she might enter into sexual relations with fellow patients to cope with these feelings.

At times there is, as illustrated, a high turnover of doctors leading to superficial therapeutic relationships and contributing to the loneliness of patients.

In contrast to the above, the following quote:<sup>21</sup>

I: Why Dr Y, what made her important?

P: Well, she ... I think it's because she's been with me on this road ever since last year...

### **9.2.2 Negative encounters**

First impressions are always important, this includes the hospital environment. Patients scan and observe the environment, sometimes subconsciously. If the environment is 'good enough', this is registered and the patient can move on, like the patient describing Central Admissions as nice, but then immediately carries on commenting about and focussing on the nursing staff.<sup>22</sup> Their attitude gets to her, or at least the way she experiences them. She is left waiting, things are done slowly and it takes several hours until she finally reaches the ward. Before that, she also has to endure their questions and feels that the manner she is questioned about her substance abuse increased the guilt feelings she already suffers from. In the end, she wonders whether it was the correct decision to come for admission to WKH.

It can be helpful to keep in mind that we are hosts and that our patients are our guests, as put by Sweet (2012).

---

<sup>21</sup> From Section 7.2.2.

<sup>22</sup> See Section 4.1.

Admission can then be either to a closed or an open ward. Several patients have mentioned that a closed ward feels more like a jail; to be in such a ward was “tough, really tough”.<sup>23</sup> Participants complained about being locked into their dormitories for up to 17 hours per day. Not knowing the time added to this distress; it increased feelings of uncertainty and helplessness. Patients will rattle the steel gate to let the nursing staff know about their feelings, their impatience and wishes to be let out.

We seldom reflect on what it means to know the time; we take it for granted. Knowing the time, however, gives a structure to the day; it can provide a sense of containment and safety for a patient. If the time is not known, it can lead to feeling insecure and lost. Being locked into a dormitory in a closed ward and not knowing how long it will take until you are attended to and allowed out into the courtyard can lead to severe impatience and irritation. This is exacerbated by the lack of structured, patient-centred activities in these wards, such as group therapy or physical activity. Boredom is a big problem - “we spend most of our time here doing nothing” - leading to more frustration.

If a patient in a closed ward becomes unmanageable, he or she is forced to take treatment, e.g. by injection of medication, or put into seclusion. Both seclusion and forced treatment are terrible, difficult experiences. Several patients in my study have made negative comments about these practices. Dack et al. (2012) found that a high frequency of coerced intramuscular use of medication negatively affects also those patients only observing these practices. Explanations and debriefing should be used to help these patients cope with what has happened.

A punitive or threatening atmosphere increases rates of aggressive incidents (Bowers et al 2010). Our closed wards are described as threatening and the stay in there as very difficult:

The feeling is like we are locked up in a jail, not in a hospital.

How can one not expect problems in such wards, where patients are locked up for up to 17 hours per day, are bored and are not engaged in structured activities?

---

<sup>23</sup> These quotes are from Section 4.5.

Worse is that four of the 15 patients in my study described nursing staff as “being violent” or aggressive. Nursing staff would hit patients, or staff and patients would hit each other. This is obviously unacceptable. It shows a serious lack of containment by the nursing staff and definitely needs to be further investigated and monitored.<sup>24</sup>

Compare this with the writings of Jungfer et al. (2014: 94): “... in the 1960s and 1970s (in the UK), all non-forensic wards were continually open, with patients being kept safe through observations and engagement of the staff”. What happened? Where is this engagement? Jungfer et al. (2014) write that closed doors have replaced this interaction, which might lead to an increase in involuntary treatment and the use of safety measures such as containment. Similarities seem to exist between what Jungfer et al. describe and what happens in some or many of our closed wards: little interaction between patients and staff (patients described being locked up for 17 hours per day), more frustration and then more restrictive measures. In addition, with staff I mean doctors, psychologists, occupational therapists, social workers and nursing staff – in other words, all members of the MDT.

Noteworthy is the time in seclusion noted by Jungfer et al. (2014) of 18 hours – 24 hours in their study in Switzerland. In the UK, seclusion is rarely used and the average time for physical restraint is only 20 minutes (Steinert et al. 2010). The short time of restraint and rare use of seclusion in the UK is something we should definitely take note of; the message is that a long time in seclusion is often not warranted. It is interesting that in Iceland there is no use of seclusion or of any coercive methods, but there is 1:1 nursing (Steinert et al. 2010). The handling of such situations therefore depends to a large degree on well-trained nursing staff and especially having enough nursing staff.

In my study, patients who were finally transferred to an open ward received this news with gratefulness; this happening alone already changed the patients’ attitude towards the hospital. All of a sudden everything looked better; there was so much more to enjoy, for example the surroundings and having their ‘own space’, the bad experiences in the closed wards were even ‘forgotten’ or (apparently?) forgiven. There is then, however, a split in the minds of these patients – the bad experiences were not discussed and are not integrated.

---

<sup>24</sup> I take this up again in Section 11.3.

What happens to these bad experiences if they are not integrated? How does it affect the interaction between the patients and the team and their compliance or collaboration with treatment?

The important message is that we need to minimise measures such as admitting patients to a closed ward or putting them into seclusion. Other options need to be explored, such as a personal way of containment wherever possible.<sup>25, 26</sup>

Other negative experiences centred on the experience of helplessness. We live in a time in which collaborative health-care is emphasised. A shared-decision making model, in which decisions are reached through discussions between physician and patient and where the patient plays an active role in this decision-making process, is recommended where possible (Charles et al. 1997; Moreau et al. 2012). The following quote is an example of this not happening:<sup>27</sup>

...my doctor is the one that's going to see to it that I get to be on the open ward, where I will be able to wake up probably around the time 5 and take a shower and then do things normal like any other person would do. Yes, but now it doesn't happen like that, eish,<sup>28</sup> it becomes a problem. I feel very much more at the mercy of our doctors ....

In thinking about negative experiences, body language needs to be considered as well. Patients, subconsciously or consciously, observe the body or non-verbal language of doctors. Words can conceal the truth, but non-verbal signs may at times be more truthful and are used to check on the validity of communication (Bateman et al. 2010).

---

<sup>25</sup> I discuss containment in Section 9.3 and 11.4.1.2.

<sup>26</sup> In the weekly meetings that I started a few weeks ago with the patients of our open ward for females (see Section 11.5.4), patients have told me that nursing staff will at times threaten them with a closed ward and that, as a consequence, some live in fear of being sent there. In our most recent meeting, a patient told me to my surprise that she has to go to a closed ward after our meeting. She had acted aggressively earlier that morning, threw the sister with a bottle and was telephonically prescribed a tranquiliser and referred to the closed ward by the registrar, who had not seen the patient. I discussed what had happened with the nursing staff members and the patient after the meeting, reversed the decision after the patient had apologised to the staff member and took this up with the registrar. Up to now (seven days later) the patient has not shown any further aggressive behaviour. These are further examples of a lack of containment and inappropriate handling of such situations.

<sup>27</sup> From Section 5.2.4.3.

<sup>28</sup> Eish' is an African word expressing exasperation or disbelief (Urban Dictionary).

### 9.2.3 Meaningful encounters

#### 9.2.3.1 **Seemingly superficial encounters that can be meaningful**

Many experiences that seem superficial are of importance to patients. Interactions with fellow patients are usually short-lived and fraught with possible complications, yet such interactions can be very supportive and therefore meaningful to patients. Thomas et al. (2002) found that socialising can be important and that patients feel solidarity with other patients. This I can only echo – for 10 of the 15 participants, fellow patients were important to very important, for some even the most important people in the hospital. They would socialise, share their problems and get support from each other.

Even if encounters stay superficial, it can still be important to have another person I can talk to. Small gestures can be seen as superficial, but they might also be the expression of a deeper feeling of empathy and connectedness. Putting a hand on the shoulder of a patient, a pat on the back, a hug – small gestures that take little effort – were remembered by participants as something important. “She (*the nursing sister*) would at times just give me a hug and ask me how I am; as if she can sense that I’m not well. Or pat me on the back...”<sup>29</sup> Several patients described interactions that I would define as superficial, yet for them it was very meaningful. However, several did also long for a deeper connection, an example is one patient wishing that her therapeutic relationship with the registrar could be better.

Showing interest in the patient and being respectful is received with gratitude, as is when staff really listen to a patient. Physicians often feel they have to *do* something, but allowing a patient to just express their problems to a staff member was deemed to be helpful. Waiting for a response was at times not even mentioned, countering the idea that we always have *to do* something. Just talking to someone was enough. “...last night I talked to a nurse and she listened, and I could go to sleep because she had listened”.<sup>30</sup>

If there is no help or containment provided by staff, a patient has to look to other ways of coping and staying hopeful. Fellow patients can provide this. A very interesting example of

---

<sup>29</sup> From Section 5.1.1.3.

<sup>30</sup> From Section 5.1.1.2.

this was the fourth participant who described his fellow patients as role models, even though they were at times acting strangely!<sup>31</sup> This patient had been in a closed ward for several weeks; he felt forgotten by his registrar and was not seen by any other team members. The registrar did not discuss the treatment process with him, leaving him with a lot of uncertainty. Coming from a patriarchal society, he accepted the situation without demanding clarification. To cope with this, he looked up to those fellow patients who had been locked up in a closed ward even longer. If they were cooperating, it meant that they still had hope and thus he could also hope for a transfer to an open ward in the near future.

The other patients were role models because they somehow managed to endure the present situation, to endure whatever difficulties were thrown in their path. This patient's story tells us how much patients can mean to each other, even if there is not much communication.

Another example of an interesting encounter was between the 30-year-old patient studying for her master's degree in the arts, which included psychology as one of her subjects, and an elderly fellow patient. From a certain point of view, this interaction looked very superficial, the other patient responded at times in inappropriate ways:<sup>32</sup>

I: Do you have anyone in hospital with whom you feel you've got a close relationship?

P: It's the patient.

I: The patient. ...Why that patient?

P: It's because she is older than me and I can relate to her for advice. I'm not scared to tell her everything or how I feel, because she is not judgmental. She is going to give me the correct advice, although sometimes I feel her mental capacity is sometimes affected. ... She keeps my secrets ... sometimes she doesn't understand what I'm saying. Her response is maybe inappropriate at some instances.

---

<sup>31</sup> Quoted in Section 5.4.1.

<sup>32</sup> See Section 5.4.1. This is the 12<sup>th</sup> participant.

This patient was able to correctly judge the inappropriateness of some of her fellow patient's responses and form an opinion of her mental capacities, yet this young, intelligent woman felt the closest to this older woman. Why? Why rely for advice on someone whose mental capacity you judge to be at times affected and who does not reach you at a deeper level?

My thoughts about this are:

- The fellow patient is older and probably a mother figure; relating to other patients as a mother figure was mentioned by other patients as important.
- The fellow patient was accepting and not judgmental.
- There is some sense of understanding.
- The other patient is able to keep secrets and is trustworthy.
- The young patient is, however, prepared to suspend her judgment on the depth of this interaction. It is amazing that this young psychology student accepts advice from someone who at times does not understand what she is saying. The interaction must cognitively be on a superficial or very superficial level. Bettelheim (1987) wrote that when parents seek advice about child rearing, it is often done in the hope that this advice will confirm their own already held beliefs. We ask for advice, but actually we want our point of view to be vindicated. It alleviates our anxiety; we don't really want to be confronted with something new. It can thus point to an unconscious process of resistance and an infantile wish that all problems can be solved by advice and that there is no need for inner change.

This is another unusual example of an interaction being (apparently) helpful even without the other really doing something else than just listening – and at times giving inappropriate answers.

My conclusion is that a patient can be very satisfied with a superficial encounter, in which no deep connection happens. There just needs to be a person to whom I can talk, with whom I can share my secrets and my burden. There is no painful searching for a way forward, but satisfaction with superficial advice. I just need to feel that there is a person out there for me, with whom I in some way can connect. (Obviously this does not apply to all patients; many are expecting something else, or more.)

### 9.2.3.2 Encounters with religion, spirituality, culture and language

#### Religion and spirituality

Religion and spirituality are important to many people and can provide meaningful support to psychiatric patients, but can at times also cause inner conflict. Two patients described their struggle to understand whether, or how, their religious experiences were linked to their mental illness.<sup>33</sup> A patient described that twice after “giving his heart to Jesus” he became ill. It seemed to him that there was a correlation between the two and he had a wish to understand this. The team had apparently not taken this up with him.

In another patient, a manic episode was seemingly triggered by a service in his congregation that continued through the whole of the night. Again, this was apparently not taken up by the team.

The despair of one patient during her stay in a closed ward and seclusion was expressed in her crying out to God:

It is hell. Life can be hell. Life can be hell. At times you feel: God are you still there, are you still there?

It is in my opinion advisable to include religious or spiritual advisers or counsellors in such situations, as also mentioned by Janse van Rensburg (2014b) in the guidelines for the integration of spirituality in the approach to psychiatric practice.

#### Language, culture and tradition

For all of us, language, culture and tradition are things into which we are born and in which we live. It is the air that surrounds us and that we breathe, in other words, it can be a type of holding environment. We are compulsively driven to belong to a group; Wilson (2014) writes that it is hardwired into us. If I am in my group, I feel safer.

Male patients were often wishing for male therapists, female patients again for a female doctor. It should preferably also be someone who understands the group to which the

---

<sup>33</sup> The quotes are from Section 6.1.1.

patient belongs. If the other, the helper, is from a different language or cultural group, then the patient may encounter this 'otherness', and with that a possible feeling of strangeness, of not being at home, or not feeling safe. For the patient the focus is then not only on their problems, but also on the interaction, a possible cause of more stress.

The importance of language was expressed by several patients and is understandable for the reasons mentioned. Certain patients are also not able to express themselves well in another language. This emphasises the need to train professionals from various cultural and language groups in a country as diverse as South Africa and for trained professionals to further their knowledge of other cultural groups and their languages.

### **9.2.3.3 Meaningful deep encounters**

A meaningful deep encounter is to me an encounter with a person who has a certain wisdom about life and relationships and who really tries to understand me, who is really present, who listens and with whom I can exchange thoughts about matters of importance. It is an encounter in which I can gradually open up, since I sense that this person is trustworthy and sincere.

In the literature review, I mentioned several important building blocks for developing a meaningful therapeutic relationship, such as empathy<sup>34</sup>, verbal and non-verbal behaviour<sup>35</sup> and the ability to really listen.<sup>36</sup>

A relationship starts by listening to each other. Listening is perhaps the most basic of all helping skills, yet not all in the helping professions attend to this, or are able to really listen. If a doctor can listen, patients react in a very appreciative way. The sixth participant had such a registrar and he desperately wished to follow up with this registrar and not to see the next registrar, as would be dictated by the four-monthly rotation. This same registrar was described by another patient in the following way: "He listened more than he even asks you".<sup>37</sup>

---

<sup>34</sup> Section 8.4.4.

<sup>35</sup> Section 8.4.6.

<sup>36</sup> Section 8.6.5.1.

<sup>37</sup> Quoted in Section 5.2.2.

Through listening, a space is opened and, as described by Del Piccolo et al. (2012), this is necessary to allow for *cues* given by patients to be clarified. The following quote is from the interaction between a patient and her young, female registrar. It is a good example of opening up a space for a patient and heartening that this young registrar has this ability:<sup>38</sup>

I didn't want to speak about things that maybe bothered me. But the manner she approached the situation, made you want to speak about something...

For many, deep meaningful encounters were formed with fellow patients. "Fellow patients, they have been most supportive and they've been amazing to me".<sup>39</sup> Another patient had a meaningful relationship to a cleaner.

For several patients encounters then became meaningful, when the helper had been with them for a long time, e.g. social workers who were permanent members of the MDT and who had known the patient and the family for years. A social worker recently told me that there are other team members who are more important than social workers. I responded by saying that I would not like to grade the importance of team members, especially since one of the participants of this study described his social worker as the most important team member to him; it was she who had accompanied the patient and his family through all the difficult times caused by his illness. Recently in a ward conference, a patient told us about a psychologist she saw nine years ago. She still remembered that psychologist and said that, apart from being competent, this psychologist had seen her for a longer period of time than the usual four months, which was of great importance to the patient and had made the encounter meaningful.

#### **9.2.4 Reflections on encounters**

A patient commented on her new registrar as follows:<sup>40</sup>

---

<sup>38</sup> Quoted in Section 5.2.2.

<sup>39</sup> From Section 5.4.1.

<sup>40</sup> Quoted in Section 5.2.4.3.

Because I was superficial, and it was the first time he met me, so he couldn't, he didn't know that I've relapsed. And the fact that every time you come to admissions you're assigned a new doctor, new doctor, new doctor... If your doctor doesn't know you, it becomes very difficult for them to read that you have relapsed.

Balint (1985) voiced as early as 1930 (!) the concern that the intimate relationship between the patient and doctor had almost totally disappeared, replaced by quick and superficial dealings. This is how many participants in my study have described their interaction with their registrars. The psychiatrist and philosopher Karl Jaspers (1986) says, in a talk given in 1958 but published as part of a book in 1986, that in the diagnostic and therapeutic process more and more apparatus is being used; the patient finds himself confronted with this technical world, of which he understands little. In this process, he or she is faced by many physicians, of which no one is *his* physician (italics in the original). This comment by Jaspers, that no one is *his or her* physician anymore, was echoed by the patient who had six or seven different doctors in WKH.

Jaspers concludes that the physician has apparently turned into a technician. Technicians work with objects, with 'things'. The ethical demand of our day, according to the psychoanalyst Erich Fromm (1963), is to overcome this concept of man as 'a thing'. He actually stated this 50 years ago, but the problem seems to have stayed the same, only more intensely so. Does a patient who feels that he or she is only a number not feel like a 'thing'?

Engel (1980), stated more than thirty years ago that the dominant model in medicine was the biomedical model, but that the crippling flaw of this model was that it did not include the patient and his attributes as a person, as a human being. (He was thus also referring to 'a thing'.) Engel emphasised the "on-going human relationship" (Engel 1980: 536) between physician and patient and therefore introduced the biopsychosocial model in 1977, based on a systems approach, to counter the preoccupation with the body and with disease and the corresponding neglect of the patient as person.

In the last two decades, there is a move from a biopsychosocial to a biopsychosocial-*spiritual* approach. This is linked to a vision of human development and potential; a vision linked to health *and* meaning. Here, the six definitions of mental health given by Vaillant (2003) are important, especially the definitions of mental health as positive psychology (Peterson and Seligman 2004), where the strengths or virtues of love, temperance, wisdom, knowledge, courage, justice and a sense of transcendence are emphasised, and mental health as maturity (Menninger 1967), with the capacity for love, the absence of stereotyped and unproductive patterns of problem solving, the realistic acceptance of one's destiny, appropriate expectations and goals for oneself and the capacity for hope.

The WPA has established the 'Institutional Program of Psychiatry for the Person' in 2005, aimed at promoting a person-centred approach to psychiatry (Mezzich et al. 2010; Mezzich et al. 2011; Miles and Mezzich 2011). The relationship between doctor and patient is thus at the centre.

Mikesell (2013) writes that the patient-doctor relationship and communication seem to be more important to patient satisfaction than doctor characteristics such as age and experience. This is quite an astonishing statement, but it is echoed in my research:<sup>41</sup>

Dr L is a very good doctor. He really...he listens carefully to what you are saying.

Furthermore, relationships stimulate the inner growth of the person, something this patient expressed:<sup>42</sup>

I: How do you think that affected you, that you did not have such a therapeutic relationship?

P: I think it has blocked me from growing actually. It has not allowed me to grow....

For most participants, relationships were important. In my study, only three patients stated that relationships were not important to them, and all three suffered from a psychotic

---

<sup>41</sup> Quoted in Section 5.2.1.3.

<sup>42</sup> Quoted in Chapter 7.1.

disorder; two of these three had had a very difficult childhood, and two lived presently in very difficult circumstances. Only three of the 15 participants, however, had a good to very good therapeutic relationship with their registrar, a fourth participant had a fairly good interaction with her registrar.

My findings confirmed my suspicion that therapeutic relationships between registrars and patients are more the exception than the rule. I have mentioned how many doctors some patients in WKH see – up to eleven in eight months for the one patient – an indication that there is no therapeutic relationship and that such patients are rather ‘managed’. A senior registrar told me recently that to see psychotic patients more than once a week does not make sense, since the medication needs time to kick in. This comment is another indication of a lack of understanding about a therapeutic relationship and what such support can mean to patients, including psychotic patients.

This is a worrying situation. Are registrars not interested in a therapeutic relationship? Or plain overworked? Or are they not aware of this being a problem? Or are they not able to interact with patients on such a level? Do they, apart from a good foundation in the biological aspects of psychiatry, have the skills of building relationships, which depends on their own maturity and on some understanding and interest in the human condition, as depicted in the humanities?

Two weeks ago (December 2014) I spoke to a young psychiatrist who recently qualified at our university and is now in private practice. I asked him how he managed the transition from seeing hospitalised patients once a week to now, in private practice, six times a week. His response was, that it is difficult and that there are colleagues who ask a locum to see their inpatients once a week to give themselves some breathing space! When I asked him whether they suffered from burnout, he responded in the negative, saying it was not burnout, but “word-out” - you “run out of words”, out of topics to discuss. In my discussion with him we reached the conclusion that a certain depth is asked for in the interaction between psychiatrist and patient, something that the psychiatrists (and registrars) are not used to, they have never learned this as registrars, since the academic pressure and patient numbers are too high. (He agreed to me citing him.) My impression is that most of them, during their years of training, never engage with the patient on a

deeper, emotional level. They do not have the time, they do not learn how to. The limited psychotherapy training that they receive is not enough to compensate for this ingrained attitude.

For the four years that I have been at the Department of Psychiatry of the University of Pretoria, I have recommended to registrars to read widely. In teaching psychotherapy, I have recommended various books to them about psychotherapy (and also great works of literature). Recently at our departmental meeting, I asked the eleven registrars present (out of a total of 18 registrars) who of them owns *any* book on psychotherapy. Two registrars answered in the affirmative, each having one such book – a very disappointing situation.

To summarise – a meaningful encounter is needed between patient and doctor, because:

- It addresses the loneliness of the psychiatric patient, as mentioned by Van den Berg (1972).
- It gives recognition to the unique individuality of the patient; it allows him or her an existence (Johansson and Eklund 2003).
- Through all of this, it influences the outcome of treatment.
- It is true to the roots and values of medicine.

The next part is on containment, since containment is the foundation of every meaningful encounter. However, the antithesis is also true: meaningful encounters provide containment.

### 9.3 CONTAINMENT<sup>43</sup>

Bowers (2006) defines containment as any method that psychiatric staff uses to prevent or manage the conflict event, methods such as seclusion, special observations, searching procedures, de-escalation, time-out, manual restraint and enforced medication.<sup>44</sup> For Bowers et al. (2013), low containment means less use of coercive methods.

---

<sup>43</sup> | discussed containment in the literature review, Section 8.4.7.

<sup>44</sup> | discussed this definition of containment in Section 8.2.3.

Containment is a central and important concept in psychoanalysis, but in a personal context. Casement (1985) and Holmes (2010) use the concepts of ‘holding’ and ‘containment’ interchangeably. In my discussion, I use the word containment to refer to both.<sup>45</sup>

In psychoanalysis, containment refers to the ability to bear with something distressing. There are times, writes Casement (1985: 132), “when people cannot cope with their own feelings without some assistance. We could then think of these feelings as spilling over towards others”. The spilling over, or inability to contain, is a sign that something is amiss, that something is unmanageable without help. Medication can subdue these feelings, but this does not change anything for a patient who still feels victim to powerful feelings. Medication alone is therefore often not the answer, it is not enough. A *personal* form of containment and holding is looked for. For a patient in distress, suffering from intense feelings of anxiety or despair, a personal therapeutic relationship to his or her psychiatrist or psychotherapist can provide the necessary holding and containment to persevere with life and with treatment. A patient in the grip of such feelings needs someone who can bear with such intense feelings. This is similar to a mother *holding* her crying baby to thereby provide *containment* and comfort. Deep, meaningful interactions are thus the basis of containment.

The following example, from my psychotherapy with a long-term patient, demonstrates the concept of containment. When I recently recounted in a psychotherapy training-session with registrars that I did not hospitalise a suicidal patient of mine, they reacted in surprise. I did not hospitalise this patient, because I have a good therapeutic relationship with her, a therapeutic relationship established over the considerable number of years I am seeing her for twice-weekly psychotherapy. I assessed the risk and discussed the situation and what to do with the patient – it was not a decision taken lightly. She is still in psychotherapy with me and further developments in the therapy strengthened my belief that it was the right decision. The therapeutic relationship is to her a source of strength and it helped her through this phase; it was thus a form of personal containment as described by Casement (1985). My belief in her, the knowledge that our psychotherapy will continue and the realisation that I was not overwhelmed by her feelings, that I did not crumble or

---

<sup>45</sup> I discussed the differences in Section 8.4.7.

panic, helped her through his phase – all of this provided containment, provided something, or rather someone, to hold onto. Hospitalising her might have sent out a different, non-containing message, namely that I could not bear with her feelings, or that I had doubts about both our abilities to handle difficult periods in the psychotherapy. A previous long-term patient of mine said at the end of her psychotherapy that it was of great importance to her that I never panicked no matter what she told me – also an expression of containment and it being valued by a patient.

I am not implying that suicidal patients should not be hospitalised; a psychiatrist or registrar should always err on the side of safety and a comprehensive assessment is needed in such situations.

The experience of one patient with trainee nursing staff was containing.<sup>46</sup> The patient felt treated as an equal by them, as a “fellow human being” and not as a patient. The trainees were not judging them, they were asking them questions “like normal people”. This patient’s explanation for the different attitude of the trainee staff was that they “were not exposed so much to this kind of environment”. Burnout is always a big problem and will usually contribute to a loss of containment. The patient described a deeper interaction with the trainee nursing staff than with his registrar. My interpretation of this is that the trainee staff were interested in him as a fellow human being and that there was a personal connection. Junior staff or even medical students can take note from this in that they can play more of a role in the care of patients.

If a personal form of containment and holding cannot or is not provided, e.g. because of a too heavy workload or because there is no understanding for these processes, staff will need to resort to other ‘containment measures’ as described by Bowers et al. (2004), such as medication, restraints, or even putting patients into seclusion. What Bowers et al. however define as ‘containment measures’ I would rather describe as ‘measures of control’. To give a patient medication intramuscularly, or to put him or her into seclusion, is exerting control over patients and such acts are traumatic and damaging to patients. Containment to me denotes a personal form of holding, it is not traumatic and it furthers development and growth. Steinert et al. (2010) mention that in Iceland there is no use of

---

<sup>46</sup> Quoted in Section 5.1.1.5.

seclusion or of any coercive methods, but that they use 1:1 nursing. This is an illustration of providing containment through a *personal* relationship.

The following quote, which refers to a psychotherapy session between an elderly female patient and a young psychologist, is an illustration of a lack of containment:<sup>47</sup>

I: What had happened when you broke the window of the psychologist?

P: He carried on about my son's death and the more I said, I do not know, the more he said but I should know. When he repeated that again, I became furious; I initially wanted to hit him, but I then broke the window. Then they locked me up.

The psychologist kept on probing, not realising how distressing this was for the patient. When it became too much for her and she acted out, he reacted in an overly anxious way (it was an elderly female patient, not an aggressive young male patient) and the patient was immediately transferred from an open to a closed ward. He could not contain the patient and the patient had to pay a heavy price for her actions.

Another example of nursing staff not being able to provide containment is described by a patient who mentioned that the staff do care, as long as they are *not* handled the wrong way or angered. They will help, on the condition that patients are friendly towards them. This is understandable, but containment means for staff to not react in a negative way even when patients do handle them 'in a wrong way'. A similar problem with registrars around containment was described by a patient, who said that for her the most positive experience with registrars was when she was well and showed them her creative work. *Then* they were also positive. This implies that when she was not well, difficult, or negative, their reaction was also negative, and thus not containing. But it is precisely when you are not well that you need your doctor and his or her containing support.

To create a meaningful, containing encounter it is necessary to be *present*. The 13<sup>th</sup> participant, a middle-aged woman with a degree in the arts who has been an in- and

---

<sup>47</sup> Quoted in Section 5.3.2.

outpatient of WKH for more than 24 years, had several important and interesting things to say about this.<sup>48</sup>

- Being present and showing interest in what the patient brings to you, the doctor, *at this moment*, can be more important than knowing the patient over a longer period of time, it is about the doctor's attitude towards the patient *at this moment*. It is about the energy that he or she radiates, something that he or she says, the manner how he or she greets. A doctor, she said, can radiate energy that makes a person feel safe; if they don't do this, they will create a problem for the patient and the patient will not feel safe.
- But, she said, it is more than an attitude, it has to do with the doctor's essential being, his or her essence (*wesenlikheid*). It is about whether he or she is at peace with himself or herself and able to enjoy his or her 'being'. A patient realises this *immediately*. Only then can a patient relax.
- If the doctor radiates such an attitude, a therapeutic relationship can be established immediately, in the wink of an eye, it then does not need time to develop.

If this sounds dubious, Rodenburg (2008) says something similar. Rodenburg, one of the world's leading voice and acting coaches, writes that 'presence' is nothing but energy, and that contact with such a person, a person who is really present, leaves one feeling enlivened. Such presence connects, and, she writes, is immediately felt and seen through the eyes. I would venture to say that such a person creates a feeling of safety, which is of cardinal importance to any psychiatric patient, especially if psychotic. For these patients especially, anxiety is a prominent feeling:

P: ...want jy is mos nou psigoties, niemand wil jou naby hulle hê nie, jy is 'n bedreiging vir hulle, jy gaan hulle aanrand.

I: Almal is bang.

P: Almal is bang.

P: ...because you are psychotic, no one wants you near them, you are a threat to them, you are going to attack them.

I: Everyone is afraid.

P: Everyone is afraid.

---

<sup>48</sup> She is quoted in Sections 7.3 and 7.4.

If a registrar is scared, he or she will obviously not be able to be 'present'. Usually it is only experience that will help registrars or psychiatrists to become more relaxed when dealing with difficult patients.

#### 9.4 THE MULTI-DISCIPLINARY TEAM

The MDT has become part of modern psychiatry, more so in the public than in the private sector. Most patients described the team in positive terms. Yet, for others, the team was a vague, ominous and threatening entity that in the background decides what is going to happen to you. I did quote Swartz (1998) who stated that having members of different professions available to patients would not necessarily improve the care.<sup>49</sup> Certain members may feel intimidated by 'experts' in the team and not voice their opinion. Conflict can sprout up from many different sources.

Members of traditionally less powerful groups, e.g. occupational therapists (OTs), might know the patients better than the registrars, since they are permanent members of the team who do not rotate and who see the patients on a daily basis. Because of the occupational therapist's knowledge of the patients, registrars might feel intimidated by these team members. In making decisions, even simple decisions of whether a weekend pass should be granted or not, the opinion of various team members, such as the opinion of the OT, might be of great importance, since they might have knowledge about aspects of the patient or their support structures that are not yet known to the registrar. For various reasons the registrar thus has to consult with the team about decisions. How he or she handles this might influence his or her relationship with the patient, as detailed by this patient:<sup>50</sup>

I: How do you feel about Dr Z?

P: He is a good doctor, but I've just realised that he can't make decisions by himself.

I: Oh, he has to go back to the team.

P: Ja. (Yes.)

---

<sup>49</sup> Section 8.5.7.

<sup>50</sup> Quoted in Section 5.2.4.3.

If the patient experiences the registrar as not being able to make decisions or being overruled by the MDT, this can undermine the therapeutic alliance. He might be seen as not competent enough to act on his own, or not strong enough to handle the MDT. Better ways of handling such situations would be:

- To clarify such decisions, e.g. whether a pass can be granted, beforehand at the MDT-meeting.
- If, for some reason this was not possible, then it is important how the registrar formulates his response to the request of the patient. If we take the example of a request for a weekend pass, a registrar might say: “We always work as a team, and the team usually discusses such requests, since different team members have different information. It also is simply good manners if I acknowledge my colleagues in this. I shall therefore come back to you about your request.” By responding in such a way, the registrar shows him- or herself as a responsible, communicative team player, and not as someone not able to make decisions. If he responded with: “I need to go back to the team”, he undermines himself and thus the relationship.

One of the registrars was able to handle the situation with the team so well, that the patient considered him to be the leader of the team. This registrar had spent, of all the team members, the most time with the patient, and played an important role in the decisions made in the ward conference. “He was absolutely the team leader”.<sup>51</sup> Such a positive working alliance will have a very good effect on the treatment outcome. For this reason the team has to consider and protect the various working alliances between the different team members and patients.

Two consultants form part of the MDT: the consultant psychologist, who supervises the junior psychologists and the consultant psychiatrist, who is the team leader. These two consultants do not deal directly with in-patients; they usually act only in a supervisory capacity. They will see in-patients if difficulties arise, or if there is uncertainty about how to proceed with the diagnostic or treatment process. Furthermore, they lead the weekly MDT meetings in which all patients are discussed. Otherwise, they will only see patients presented and discussed at the weekly ward conferences.

---

<sup>51</sup> See Section 5.3.1.

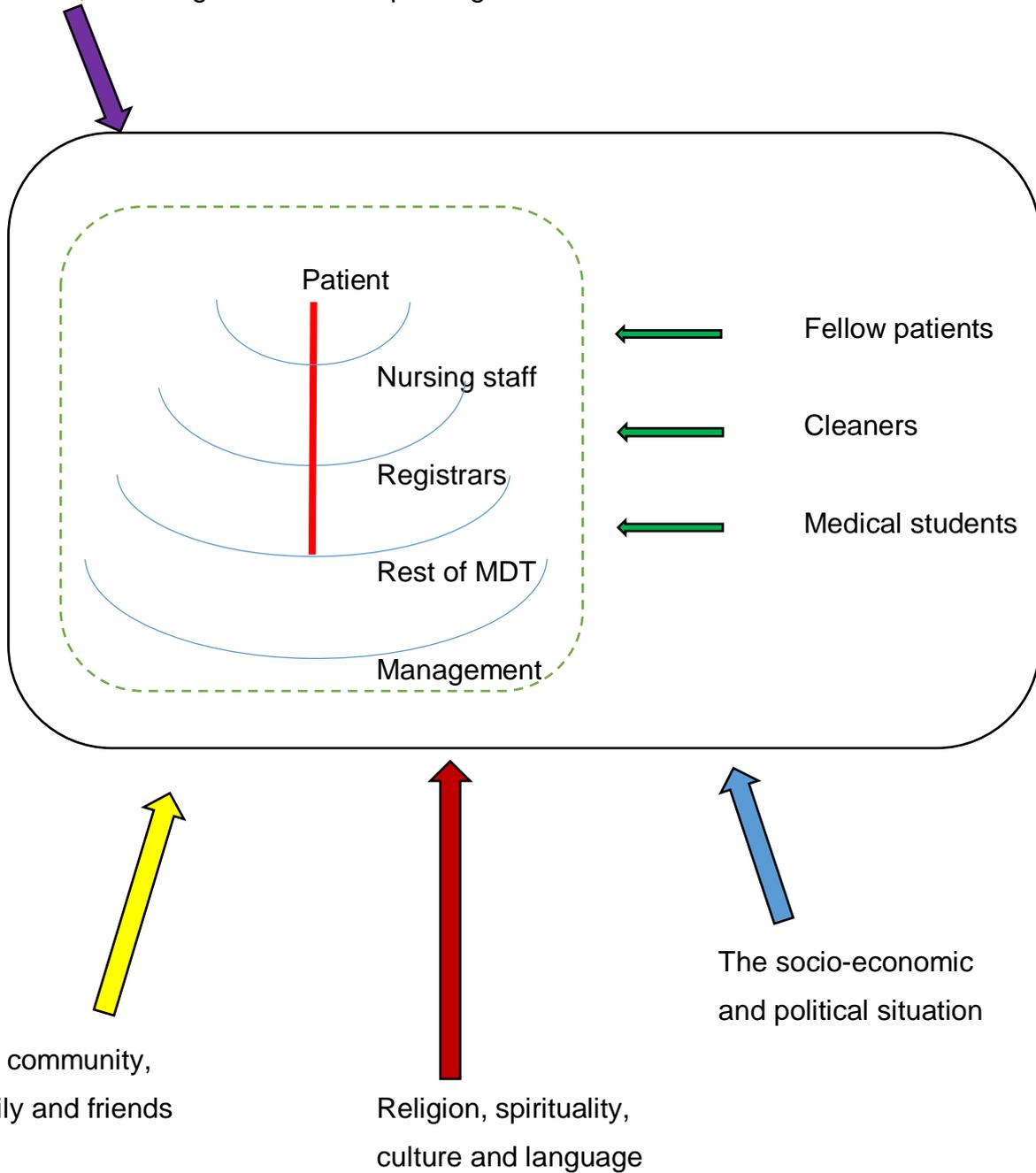
In this research, consultants were rarely mentioned by patients, and then only in passing, e.g. mentioning them in their capacity as head of a ward conference. Only once did a patient mention that he was impressed with how a consultant psychiatrist had handled the ward conference. However, this same patient had described the registrar as the team leader! The consultants thus do not really feature in the landscape of the patients.

## **9.5 THE SEVENTH MODEL: A MODEL AND SUBSTANTIVE THEORY OF THERAPEUTIC RELATIONSHIPS**

A short introduction into this model was given in Section 3.3.7. A detailed description follows in this section.

**Figure 12: The seventh model: A model and substantive theory of therapeutic relationships**

The frame, including the treatment paradigm



**An explanation of the seventh model**

To establish a therapeutic relationship in a psychiatric hospital is very different from the same goal in private practice. In a psychiatric hospital, therapeutic relationships are

subjected to many forces. The seventh model is an attempt to understand these forces and to develop a holistic model of a therapeutic relationship by keeping these forces in mind.

I shall start by examining the different aspects pictured in the model, but first I have to point out that the red bar running vertically through the inner circle represents the therapeutic relationship. This bar, this relationship, is however dependent on all the components of the model. Therefore, it needs to be kept in mind that *every* part of the discussion that follows is about the therapeutic relationship; this relationship is not only about ‘the red bar’. All the following aspects are part of or contribute to the therapeutic relationship.

### **9.5.1 The frame, including the treatment paradigm**

#### **The frame<sup>52</sup>**

The idea of a frame comes from psychoanalysis. Marion Milner writes in 1952: “I had already, when trying to study some of the psychological factors which facilitate or impede the painting of pictures, become interested in the part played by the frame. The frame marks off the different kind of reality that is within it from that which is outside it; but a temporal spatial frame also marks off the special kind of reality of a psychoanalytic session” (Milner 1952: 183).

The frame is emphasised in psychoanalysis and psychoanalytic psychotherapy or psychodynamic psychotherapy as important;<sup>53</sup> it does, however, not only denote a different kind of reality in a psychotherapy session, but also refers to the boundaries that form part of all helper-patient interactions.

I use the concept of a frame to encircle all the people and activities in the hospital. The frame divides the reality in the hospital from that which is outside, it can create cohesion for those who work ‘inside’, and defines ‘the inside’ as a huge system in which every

---

<sup>52</sup> I discussed the frame in Section 8.6.5.3.

<sup>53</sup> Psychoanalytic and psychodynamic are synonyms, referring to the same type of psychotherapy.

person, action and part affects all the other persons, actions and parts. In thinking about any person, action or part of the system, all the other persons or aspects have to be kept in mind. If, for example, one aspect 'malfunctions', the cause has to be looked for in the system, and not only in one subsection of the system.

A frame can also create cohesion and a feeling of familiarity or safety. It is, as stated by Gabbard (2010), an envelope within which the therapist can offer a personal and containing therapeutic relationship.

### **The treatment paradigm**

To me, the treatment paradigm is part of the frame, since it determines the approach taken to the care and treatment of patients. Treatment of a patient starts well before the first contact with the patient; it starts with the treatment paradigm followed by that specific practitioner or department. The World Psychiatric Association (WPA) advocates a person-centred approach (Mezzich 2010; Mezzich 2011), ensconced in a biopsychosocial or for many rather a biopsychosocial-spiritual model (Janse van Rensburg et al. 2014a). In these models, the patient-physician relationship is emphasised as important.

## **9.5.2        The inner circle**

### **9.5.2.1        The patient and the MDT**

Inside the frame, a dotted line marks off a subunit, an inner circle, which represents the MDT and their patients. Each team in WKH, for example the five teams for adult patients, form such subunits.

The patient, being the most important person in a hospital, is situated on top. Below the patient are four concave semicircles. Each one of the semicircles is supposed to symbolise a containing or holding function. Nursing staff form the first semicircle, since they are closest to the patients and fulfil a role that often equates to that of a mother. They, being around the patients the whole day, are of great importance in helping the patients cope with their situation and feelings. Just talking to them, as mentioned by several participants, can mean so much to a patient.

The registrars form the next semicircle. Doctors play a central role in any hospital, as also indicated in research that willingness to recommend a hospital depended on the nursing care and then on the care given by the doctors. Doctors not only play a containing role to patients, but also to nursing staff; this is symbolised by the semicircle extending around the circle of nursing staff. Doctors have to be aware of this duty of support towards nursing staff.

Below this is the semicircle symbolising the rest of the MDT: psychologists, OTs, social workers, pastoral counsellor and also the consultant psychologist and consultant psychiatrist. Again, they both support and help the patient, as well as the other staff.

The model has its limitations, for example all members of the MDT have to provide support to each other and for certain patients other team members might be the closest, e.g. the social worker.

#### **9.5.2.2 Management: the fourth semicircle**

Management is obviously not part of the MDT, but all role players need support from management and in this sense, management should provide a containing function to all the MDTs. Management is therefore included as a supportive semicircle in all teams.

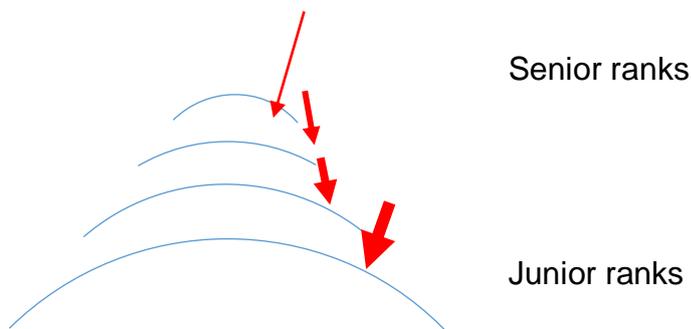
All doctors and most psychologists are joint appointees of the government as well as of the University of Pretoria. Management for these professionals therefore includes not only the management of the hospital, but also the academic leaders of the Medical School of the University of Pretoria.

#### **9.5.2.3 Illustrations of the containing function, or lack thereof, of the ‘inner circle’**

Figure 13 illustrates a system not providing containment; problems are just deflected downwards, dumped by those in senior ranks (senior ranks implies management of the

Medical School, as well as management in WKH and also consultants in the various departments in WKH, e.g. psychiatry, psychology, OT, etc.) onto the people working in the junior ranks (e.g. registrars, intern psychologists, etc.). Those working in the junior ranks then have to bear with the problem. An example is where the consultant does not accept responsibility, but leaves a problematic situation for a registrar, or takes out his or her frustrations with a non-functional system on other team members. It is like in the army, where the officer berates the corporal, who berates the troops, who have to be quiet and bear with it, but grumble with frustration.

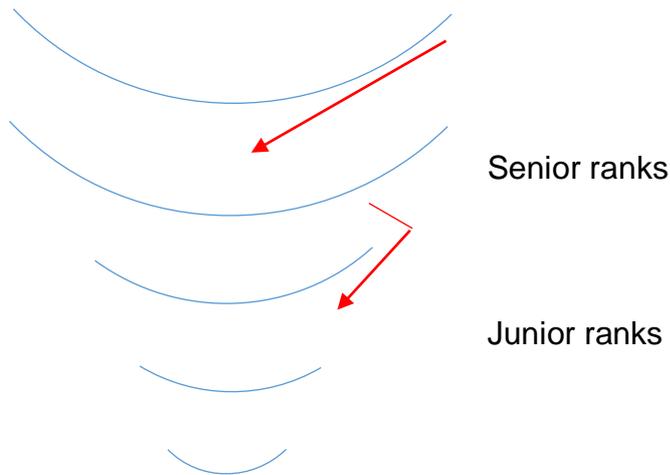
**Figure 13: Lack of containment**



The convex semicircles symbolise a lack of containment.

Figure 14 symbolises a system providing containment. The senior ranks contain most of the problems, making things more manageable for everyone involved. An example is where management accepts responsibility where applicable and does not blame the more junior ranks. Acknowledgement of contributions of others is also a form of containment. Another form of containment is where the dean of a medical school strives towards establishing an accepting, friendly and productive working environment and the head of a department does the same for his department and lower down each consultant does the same for his or her team.

**Figure 14: Containment provided**



### **9.5.3 Outside the inner circle but still inside the wall**

Outside of the dotted inner circle but still inside the wall are the fellow patients, cleaners and medical students. As mentioned in the findings, fellow patients can play an important role, mostly of a supportive nature. They become friends, confidants and even role models. However, fellow patients can also be the cause of conflict; they can be negative and criticising and through this undermine the therapeutic milieu.

Cleaners are also personnel with whom patients at times can form meaningful relationships. Speaking the same language seems to be here important to establish a connection.

Only one patient mentioned medical students, but they could play a bigger role in the support of patients.

## **9.5.4 Outside the wall**

### **9.5.4.1 The community, family and friends**

Mental illness is unfortunately still stigmatised. Acceptance and support by the community should play an important role in the care of these patients. The same goes for family and friends.

### **9.5.4.2 Religion, spirituality, culture and language**

Religion and spirituality is for many important, providing a containing function. Yet, at times, it can also be a negative factor, e.g. a fundamentalist, narrow-minded view about mental illness (Casement 1990).

I have defined holding and containment as being linked to a personal level, yet here I describe religion, spirituality, culture and language as providing holding and containment. This is not a contradiction, because to me something personal stands behind religion, spirituality, culture and language. For example, spirituality or language means to be connected, or to establish a connection to the Other/other.

### **9.5.4.3 The socio-economic and political situation**

I felt it necessary to include the socio-economic and political situation, since mental health care is worldwide a low priority, receiving little attention from government. This is also the situation in South Africa, as mentioned in Chapter 1, and it has a definite influence on our ability to deliver a good standard of care. At WKH we at times run out of crucial medication, many wards are very run down, our only ECT machine was out of order for some time and in many departments not enough staff is appointed, to mention a few examples. This obviously affects staff morale.

### **9.5.5 The red bar – the therapeutic relationship**

The red bar, symbolising the therapeutic relationship, runs vertically through the inner circle. It connects the patient to the team, or rather to the person in the team with whom this relationship has been built.

The qualities of this red bar are:

- It is thinner than in models five and six, since it is fragile and not always present.
- It runs vertically through the first three semicircles, because of the fact that a therapeutic relationship can develop with any of these MDT members.
- It does not run down to the semicircle representing management, since management is not involved in therapeutic relationships, only (hopefully) supportive of this.
- The bar is dependent on the frame, on the boundaries, on cooperation by all team members, as well as the treatment paradigm.
- Outside factors can threaten it.
- A limitation of the illustration is that the bar does not bend towards cleaners and fellow patients outside the inner circle. It should, since therapeutic relationships can also develop between patients and these persons. However, the hope is that such a relationship would develop with a member of the MDT, with the person who is primarily responsible for the patient and who has certain professional expertise in treating psychiatric patients.

### **9.5.6 Wrapping up the seventh model and substantive theory of therapeutic relationships**

A model is a partial representation of a given phenomenon, a simplification that draws attention to specific themes. For some authors the difference between a model and a theory is largely a difference of degree (De Vos and Strydom 2011). For others, a theory is more than a model; it is not only a representation, but also a set of statements that make explanatory claims about reality (Mouton 2001; De Vos and Strydom 2011). Models are

often constructed first, preferably from the findings of empirical research, and only then does a theory slowly emerge (De Vos and Strydom 2011).

My seventh model emerged from my findings; it was a slow process as depicted by the evolutionary process of developing it. The model is a visual illustration of the situation in a psychiatric hospital and the many factors involved in the interaction between patients and team members. The seven models that slowly emerged are, however, more than just models, they represent the development of a substantive theory to understand, describe and explain the factors that need to be kept in mind if a therapeutic relationship is to be realised in a psychiatric hospital.

A therapeutic relationship is not a given, even in a psychiatric hospital, but a possibility awaiting realisation. In an outpatient setting or in private practice the interaction is between patient and psychiatrist and thus more straightforward. In private practice, it is up to the treating psychiatrist who he or she wants to involve in the treatment of the patient. In a hospital setting, such as WKH, the interactions are much more complex and a whole team is always involved. Furthermore, MDT members and patients are subjected to many stressors, such as:

- The severity of the mental disorders most of our patients suffer from. The patients in WKH generally suffer from more severe psychopathology than those who can afford private healthcare.
- The severity of the social problems of our patients. We, as team, often feel helpless in a situation of overwhelming need. Many of our patients have no job, no or only a very small income and no place to stay. Some we can help, others not. If indicated we, for example, apply for disability grants for certain patients.
- The problematic ratio of MDT members vs. patients. In the state sector, the ratio of physicians to patients is much worse than in the private sector.
- The facilities, which, as described by Burns (2010), are out-dated, in a poor condition and falling into disrepair.
- The fact that at times we run out of important medication or of certain food items for the patients.

- Occasionally management, from both the University of Pretoria and the Department of Health, act in ways that are not supportive, but increase the burden we have to bear with. The higher echelons, in such circumstances, do not provide containment.

If, on occasion, the stressors become too much it can lead to acting out by MDT members. Acting out is the opposite of containment; it means, for example, saying to other team members or to patients things that should have been left unsaid, or becoming angry and blaming others. Only if the situation is contained, can therapeutic relationships blossom.

To develop a therapeutic relationship in such a hospital setting the following is needed:

- A basic knowledge by all team members of systems theory and awareness of the team as a system and of all the forces impinging on this system.
- A willing and able registrar not afraid of personal engagement with a patient on a professional level.
- A patient who is willing and able to engage with the registrar, or whose ability to do this can be furthered.
- A MDT understanding and supporting this.
- Containment on all levels.
- Enough time available to see patients on a regular basis.

Only if a therapeutic relationship is seen as an important goal and these factors are addressed, a therapeutic relationship can be realised. Then the treatment of a patient will happen within the frame of a therapeutic relationship. If this does not happen, the patient is only 'managed'.

## **9.6 OBSTACLES IN THE REALISATION OF A THERAPEUTIC RELATIONSHIP**

There are many obstacles in realising either a therapeutic relationship or improving the care in WKH. I see the following as problematic:

### 9.6.1 Superficial encounters

Many encounters in life are superficial in nature, but the question remains how our system contributes to superficial encounters between patients and staff. The contributions of the different staff members in WKH could be:

- i. A lack of interest, linked in the case of nursing staff to a lack of confidence in what they have to offer patients. Registrars, however, also at times lack confidence about what they have to offer in a personal context since they are more at home in the pharmacological treatments of patients; the registrar as person hides behind his or her role of a doctor - it is so much more safe.
- ii. Feeling intimidated by other members of the MDT. A patriarchal society still holds sway in many subcultures in South Africa, hierarchies are shown a lot of respect, and 'experts' or seniors are not easily challenged.
- iii. Not knowing the patients so well. My observation in the weekly MDT meeting is that registrars, part of the traditionally powerful rank of doctors, usually know many of the patients not as well as other members of the MDT who do not rotate, e.g. OTs and social workers. (And the OTs see their patients a few times per week.) If, for example, the OT is a very dynamic person, this can lead to an interesting interplay in the team, with registrars at times feeling a bit intimidated and unsure of themselves. They are then less assertive in the handling of patients; it is as if they do not trust their own abilities. The four-monthly rotation of the registrars (and intern-psychologists) contributes to this.
- iv. Seeing patients only once a week for routine follow-up visits. Registrars usually have a set routine, which means that they will visit a certain ward on a specific day of the week. It can therefore happen that a new patient could wait six days to see his or her registrar for their first meeting, since the patient will often have seen a different registrar for admission. Such weekly consultations are a hindrance in developing therapeutic relationships. Patients need to know what is going on and they need to meet their registrar as soon as possible. This is an important topic and I shall take it up again in Chapter 11.
- v. Having too many doctors. How is it possible that one patient (participant number 8) had seven doctors attending to her over a period of three months and another patient

(participant number 12) had eleven doctors over a period of eight months? A personal relationship is obviously impossible. Can one equate this with poor care?

- vi. Registrars have a medical background and in the medical field linear and reductionistic thinking predominates. A more thorough grounding in the humanities and in the complexities of being is missing. Training in general focuses more on biological aspects of illness.

Patients can also contribute to superficial relationships. Most patients of WKH suffer from severe mental illness. Such patients' abilities to form meaningful relationships are often impaired, they might consciously express the desire for such a relationship, yet unconsciously fear more close contact. Resistance, meaning a patient does not really want to change certain aspects of him- or herself, might also play a role.

### 9.6.2 Negative encounters

Negative encounters in WKH could be linked to three important factors:

- i. **Burnout due to treating patients with serious mental illness.** Many patients in WKH suffer from psychotic illnesses. Of the non-psychotic patients, a big percentage have a serious personality disorder. Treating these patients places a heavy burden on all staff members involved. Burnout is a constant threat. Being personally less involved in patient-care can be a way to try and cope with such a situation.
- ii. **Keeping to existing ways of patient care.** Working in WKH for a long period, for example as consultants, can lead to a blunting towards the situation patients are in. On the other hand, for new registrars it is easier to fall into an existing pattern of doing things and to not question this. Both consultants and registrars can keep to old, established ways of patient care and not really have their patients' situation in mind. Not all registrars will do this, but for some it can be a survival mechanism. One forgets how difficult it is for a patient to be in a closed ward, how helpless they can feel.
- iii. **A lack of containment.** Staff of WKH are exposed to stressors from many sides, e.g. expectations and pressure from the University of Pretoria, as well as from the Department of Health. Happenings 'outside the wall' affect what is happening 'inside

the wall'. This can lead to stressors becoming too much to be contained. What then happens is a process as illustrated in Figure 13 (in 9.5.2.3): the buck is passed 'down'. This does not mean that this needs to be a visible, observable process; it can happen with no one being conscious of it. There can, for example, just be a general atmosphere of unhappiness, or apathy and a distancing of oneself from real involvement. At other times, it can lead to conflict between staff, or between staff and patients. All people in the system influence each other - people can buffer changes, or cause a snowball effect, worsening the situation for each other.

### **9.6.3 Splitting of the bio-psycho-socio-spiritual approach**

Even if a biopsychosocial-spiritual approach is followed, splitting can happen. In this context, I mean the splitting of a holistic approach between team members, e.g. the registrar attending to the medication, the psychologist to the psychotherapy and the social worker to the social aspects. The treatment is then not integrated, but rather fragmented. I would describe this as managing the patient.

How does this however differ from so-called split treatment in psychiatry, a valid approach taught to registrars? Is it correct if I call it fragmented? I think it is fragmented if the different members of the team are not able to hold the whole treatment-picture in their minds; if registrars, for example, are not able to understand the approach needed and hopefully taken in psychotherapy by the psychologist.

If team members *do* understand the total picture, if the team is cooperating and if there is constant communication between members, then the patient will feel that there is an integrated approach in which team members share the same vision. If this happens, it is an indication that the registrar is also educated in the psychotherapeutic approach and able to hold different points of view in his or her mind.

## **9.7 HOW COMMON IS A THERAPEUTIC RELATIONSHIP?**

I started this research with the assumption that many registrars have a biological and symptom-orientated approach to patients and neglect the therapeutic relationship. Furthermore, that patients often feel disconnected, but have a wish for a therapeutic relationship and to be understood. If a therapeutic relationship does not develop with their registrar, therapeutic relationships with other team members or with fellow patients become more important.

My research showed that only about 20 per cent of the patients (three out of 15) seem to have had a good to very good therapeutic relationship with their registrar, but for about 66 per cent of patients (10 out of 15) their fellow patients were important to very important. That fellow patients are really very important is again highlighted in the group meetings that I am at present conducting with patients on a weekly basis. Most registrars see patients only once a week for routine consultations and these consultations are usually short and symptom-focussed. The focus is mostly not on building a relationship, but on managing symptoms. The literature review clearly states that neglect of the therapeutic alliance will have a negative influence on treatment outcome.

## **9.8 SOME CONCLUDING REMARKS ON THE MODEL AND SUBSTANTIVE THEORY OF THERAPEUTIC RELATIONSHIPS**

Most doctors who decide to specialise in psychiatry have, in my opinion, a heightened sensitivity to existential, spiritual, religious and psychological questions. In my study, most registrars had however a symptom-based, biological approach to patients. A person-centred approach is lacking. Why this difference?

Registrars come into psychiatry after studying the human body and its different biological aspects for many years. They do not study the human sciences. They are trained in and familiar with the biological paradigm, a very powerful paradigm. A paradigm supported by fascinating research about the brain, by new discoveries made and the hope of a better understanding of the genetic and biological underpinnings of psychiatric disorders. This

way of thinking is, of course, also promoted by the pharmaceutical industry. A lot of power and money is invested in this biological model.

Doctors are furthermore trained to accept responsibility for their patients and the treatment. Even in an age in which collaborative care is emphasised this still holds true. Doctors are used *to do* something for their patients. And psychiatrists are still doctors.

The biological approach is also more simplistic. A diagnosis is made according to the symptoms of the patient and by following a diagnostic classification system such as the DSM. Then medication is prescribed for that disorder according to an algorithm. (Obviously, the biological aspects of mental illness are hugely complicated, but the approach followed with our present state of knowledge is simplistic.)

Contrast this with the approach taken, for example, in psychodynamic psychotherapy. Here you cannot *do* something for a patient in a medical sense, the interactions are much more complex and it takes much more time. The psychotherapist has to endure uncertainty and ambivalence, he or she has to have the ability to bear with many difficult feelings. The whole process depends not only on his or her knowledge, but also on their level of maturity. Personal factors come into play.

This research was however not about psychotherapy, but about the role of therapeutic relationships in the general psychiatric treatment of patients. Why are such therapeutic relationships the exception and not the norm? Why are the interactions between patient and registrar often superficial or negative? In Sections 9.6.1 and 9.6.2., I tried to give answers to these questions.

In my opinion, central to this problem of a scarcity of therapeutic relationships is the dominance of the biological paradigm as already outlined, the pressure registrars are working under and a lack of containment. Such a situation can lead to a greater use of 'measures of control', such as the admission or transfer of patients to closed wards, or the use of compulsory intramuscular medication.

The seventh model is the visual representation of a substantive theory of containment and therapeutic relationships in a psychiatric hospital. Only in a containing environment can

therapeutic relationships blossom, since whatever happens in a hospital cannot be seen in isolation, but is part of a complex inter-related system and has to be seen from a systems point of view. Containment should ideally be provided through a personal, professional relationship with the registrar/psychiatrist or with another team member. For this to happen the following is needed:

- An appropriate person-centred treatment paradigm.
- Mentors who practice according to this treatment paradigm.
- Support from the 'higher ranks' from outside and inside the hospital.

Containment of the patients ultimately depends on whether the general attitude within and outside of the registrars' line function and in the whole of the hospital is one of containment. The question is whether the hospital sees itself as a community that radiates a sense of hospitality, as expressed by Sweet (2012).

## **9.9 SUMMARY OF CHAPTER 9**

In this chapter, I gave a summary of the most salient findings with the patients. I described different types of encounters in the hospital, followed by a discussion on containment and the MDT. An analysis of the seventh model was given, with attention to all the different aspects and people involved in this model and substantive theory of therapeutic relationships. Then I gave a description of what is needed to realise a therapeutic relationship, discussed obstacles in the realisation of a therapeutic relationship and reflected on how few patients in my study had such a relationship. I ended with a review of the substantive theory developed by me.

## 10 AN ANALYSIS OF THE TRUSTWORTHINESS OR ‘GOODNESS’ OF THE STUDY

In this chapter I reflect on matters concerning the trustworthiness of the study and how this impacts on the goodness of the study. I also discuss the ideas I have brought in to enhance the quality of a qualitative study.

### 10.1 CONCERNS ABOUT CASE STUDY AND INSIDER RESEARCH

Case-study research is sometimes questioned for validity and generalizability and whether it is suited for fully-fledged research schemes. According to Flyvbjerg (2004) the conventional wisdom about case-study research rests on the following five misunderstandings or oversimplifications about this type of research:

- i. General, theoretical knowledge is more valuable than concrete, practical knowledge.
- ii. One cannot generalise on the basis of an individual case.
- iii. The case is most useful for generating hypotheses, while other methods are more suitable for hypotheses testing and theory building.
- iv. The case study contains a bias towards verification, that is, a tendency to confirm the researcher’s preconceived notions.
- v. It is often difficult to summarise and develop general propositions and theories on the basis of specific case studies.

Flyvbjerg goes on to refute each of these allegations; for example, he quotes results of many studies to show that case-study research contains a greater bias towards falsification of preconceived ideas than towards verification.

Van Wynsberghe and Khan (2007) state that a case study design allows researchers to develop working hypotheses and learn new lessons, and opens up the possibility of ‘extendibility’ from one setting to others.

An in-depth case study of the patients in Weskoppies Hospital allowed me to explore and better understand the complexities of the hospital and its staff, all part of a big system.

From this detailed understanding, generalisations could be made about the happenings within a team and the development or not of therapeutic relationships.

About insider research, such as this project of mine, Creswell (2013) raises the following concerns:

- i. Such research may raise issues of power and risk to the researcher, participants and the site. Data collection may introduce a power imbalance between the researcher and the participants. Can good data be collected in such circumstances?
- ii. Researchers can jeopardise their jobs if they report unfavourable data.
- iii. Will multiple perspectives, a hallmark of good research, be reported?

I did keep these concerns in mind during data collection. My impression was that the participants felt safe enough to report their experiences. Their eagerness to talk to me supports this opinion of mine. In reporting, I tried to view the data from different perspectives and to keep the complexity of the situation in mind. My seven models and bringing in a systems point of view corroborate this.

There are also advantages in doing insider research, as mentioned by me in Section 2.7.1: 'Study setting'. I am of opinion that the advantages outweighed the disadvantages. My intimate knowledge of the situation helped me to gain a better understanding of the experiences of the patients.

## **10.2 THE TRUSTWORTHINESS OR 'GOODNESS' OF THE STUDY**

Questions linked to the trustworthiness of the study are (i) how valid and correct the information given by the patients is; (ii) how valid is my rendering of the information gathered, and (iii) how can I be truthful to the findings, yet phrase the findings in such a way that the interpretation and recommendations can be heard and be considered by all staff of WKH, as well as by decision making politicians.

I address these questions with an analysis of the goodness of the study. Assessing qualitative research is not an easy matter and researchers hold different opinions on how

this should be done (Schurink et al. 2011). The criteria I followed in assuring quality were reflexivity, an audit trail, triangulation and crystallisation, peer debriefing, thick descriptions and member validation.

### 10.2.1 Reflexivity

Reflexivity, according to Creswell (2013), refers to the 'presence' of the researcher in the research account; reflexivity points to the author being aware of the values, biases and experiences he or she brings to the study, and this is made explicit in the text. Richardson, in writing about reflexivity asks, "(h)ow has the author's subjectivity been both a producer and a product of this text?" (Richardson and St. Pierre 2005: 964). Is there adequate self-awareness and self-exposure?

This study is actually a continuation of an inner process of mine that started a few decades ago: How to understand and develop relationships. If I think chronologically, my journey was initially a religious/spiritual quest under the guidance of a mentor, during which I also built a basic foundation in the human sciences. Then the interest in psychoanalysis followed, especially as formulated in the British school of object relations theory. Numerous psychoanalysts have contributed to this school of thinking, e.g. Klein, Bion, Winnicott and Fairbairn (Ogden 1986). Object relations theory is "a theory of unconscious internal object relations in dynamic interplay with current interpersonal experience" (Ogden 1986: 131). Interpersonal relations are thus a focus point. A very important part in learning about psychoanalytic theory and therapy was my own training-psychotherapy of several years. Another interesting learning experience was to learn how to fly a light aircraft six years ago. I flew with several instructors, from young newly qualified instructors, to the owner of the flying school, to a test pilot for helicopters. I learned that instructors can be compared to psychotherapists – holding and containment form (or should form!) an important part of training, especially if you practice stalling and spinning at 8000 feet.

My background therefore played an important role in how I approached this subject. Many background thoughts were constantly playing in my mind and influenced decisions. Psychoanalysis has taught me to stand back, to observe and to reflect about myself, and

this has definitely helped in this study, although I am very aware of still having blind spots (and not knowing about them!). I tried however to think about this topic from various angles and to keep different points of view in mind. I think my seven models<sup>54</sup> are an expression of this, of keeping the existential problems of the different staff members in mind, to not point fingers, but to see the problem in its complexity.

### 10.2.2 Audit trail

“An auditing trail is a systematically maintained documentation process of the researcher’s continuous critical analysis of all decisions and actions taken during the entire research process” (Schurink et al. 2011: 422). It is about *how* things were discovered, a continuous critical analysis of the researcher’s thinking and feeling about all aspects of the research process; it is the questioning of one’s own involvement “and turning a self-critical eye on one’s own authority as interpreter and author ...” (Schurink et al. 2011: 422).

Aspects of the audit trail include the following:

- All the transcriptions of the interviews are available for audit. I selected the many quotes from these transcriptions and weaved them into a pattern. In my theoretical notes, I kept track of themes that emerged.
- I see the development of the seven models of containment and therapeutic relationships as an important part of the audit trail. The models are a representation of my efforts to try to make sense of the data gathered. The seven models are a visual representation of my continuous critical analyses of the research process and how to think about it. They illustrate how the idea of containment gradually became important to me and the realisation that I need to see the situation from a systems point of view.
- I kept field notes from the beginning and a personal diary to document the research process and my thoughts and feelings about it. Both field notes and a diary are ways of keeping the study in mind and mulling things over.
- In my personal notes, I kept track of what I was reading at that stage, e.g. three books on psychotherapy, and how that stimulated thoughts on how to understand my study and the findings.

---

<sup>54</sup> The seven models are discussed in Section 3.3.

- The field notes and personal notes helped me to reflect on my interview technique and on different aspects of being with the patients. Theoretical notes helped me to reflect on patients' experiences in the hospital.
- I kept notes of my discussions with my supervisor about specific problems encountered, how to understand what patients reported and what to do about these findings.
- The evolving questionnaire is also part of the audit trail. After seeing the third patient, a rather quiet and introverted person, I expanded the questions on experiences and relationships in the hospital, as well as on the environment and the care received. The questionnaire grew in the first three weeks of the data gathering process from 22 to 35 questions.

### **10.2.3 Triangulation or crystallisation**

Triangulation, writes Richardson, is valued in traditionally staged research (Richardson and St. Pierre 2005). It means that different methods are used to validate data; the assumption is that there is a 'fixed point' or an 'object' that can be triangulated. Richardson proposes that the central image for 'validity' for postmodern texts should, however, be the crystal and not the triangle. A crystal combines symmetry and substance with an infinite variety of shapes, multi-dimensionality and angles of approach. Crystals grow, change and are altered; they reflect but also refract what comes from external, creating different colours and patterns. "Crystallization, without losing structure, deconstructs the traditional idea of 'validity'; we feel how there is no single truth, and we see how texts validate themselves" (Richardson and St. Pierre 2005: 963).

I want to add to Richardson's description (Richardson and St. Pierre 2005) my own interpretation of crystallisation, which is another way of looking at it. To me crystallisation as validation strategy is also about the ability to wait, because only then something can crystallise. Important, however, is to take note that this is an active and not a passive form of waiting. Active waiting includes reflecting about the study and thinking about the process and the findings. It is more a mulling things over than a goal-directed thinking. At times, it involves sitting back and allowing the unconscious to work on problems. Then,

with time, certain aspects will crystallise, will become clear. This process is illustrated in one of the great western films, *Once Upon a Time in the West*, (1968, directed by Sergio Leone). While many other things are happening in the movie, to me a central underlying theme, continuing right from the first scene, is the ability to just wait. The main character, played by Charles Bronson, does not know whom he is hunting down; he can only wait for the image in the Fata Morgana to become clear. He seems to just hang around, doing nothing. In the beautifully crafted opening scene, three thugs are waiting, just waiting and also doing nothing, until suddenly the scene explodes into action. At the end of the film, it is the main character who explodes into action in typical western fashion, but the villain only dies after a truth crystallises for him, a memory surfaces, then it is over.

If one does not give up, but keeps considering a topic, keeps it in mind, certain aspects will crystallise. For me this was the process I followed in developing the seven models mentioned. I repeatedly revisited and re-analysed the transcriptions, even once more a year after the initial reading.

I also used methods of triangulation. In qualitative research triangulation means to search for convergence among multiple and different sources of information (Creswell and Miller 2000). Apart from the interviews with the participants, I also read their files, made observations of them in the wards, spoke to registrars and consultants and kept discussing the situation in the wards with the staff.

There is, however, another definition of triangulation that originated in the field of psychoanalysis, which can be helpful in the process of validation. In psychoanalysis, triangularity and triangulation are important concepts. To illustrate how these concepts are defined in psychoanalysis I quote Britton (2003: 98):

I suggest that the recognition that one has a *belief* rather than that one is in possession of a *fact* requires what I describe as *triangular psychic space*: a *third* position in mental space is needed from which the *subjective self* can be observed having a relationship to an idea.

Britton (2003) states that being able to observe one's own subjective encounter (he refers here to the psychoanalyst or psychotherapist) with the patient from a third position means having 'triangular space'; it is a process of triangulation that happens in the psychotherapist. Ogden (1986) describes this process as the achievement of the capacity to distinguish between symbol and symbolised. The ability to think in a symbolic way means to be able to differentiate between the symbol (the thought), the symbolised (that which is being thought about) and the thinker (the interpreting self). The differentiation of these three distinct entities creates the possibility of triangularity within which space is created, a space for thinking and creativity. Severely disturbed patients may be intolerant of triangulation, they cannot do it (Kernberg 2014).

If I conduct long-term psychotherapy I am an involved participant, but I also try to observe the process from a third position, to 'triangulate'. At the beginning of my career as a psychotherapist, I went for four and a half years of weekly supervision. I would immediately after a session write out the complete session as it happened, what the patient said and how I responded. Then I would discuss this transcript with my supervisor, a senior psychologist. Supervision is actually being assisted to triangulate. Apart from writing out sessions for supervision, I do not consider myself a good report writer of what happened in a psychotherapy session. I write down key words or sentences to then afterwards turn things over in my mind.

It is often only after much mulling over things and waiting that patterns start to emerge in psychotherapy and that patient and therapist can slowly start to understand and differentiate between distortions and real happenings, between beliefs and facts. In a qualitative research project, the same has to happen – mulling over things and waiting for patterns to emerge.

Apart from my definition of crystallisation, I want to introduce two other ideas for establishing trustworthiness. The first idea is the addition of the psychoanalytic definition of triangulation to the traditional definition of triangulation used in qualitative research. The second idea is the marrying of the psychoanalytic concept of triangulation with the concept of crystallisation: only if I am able to triangulate, truths will be able to crystallise. Britton (2003) says that being able to triangulate enables a person to realise that what I *believe* is

not necessarily a *fact*. Similar to a psychotherapist, a researcher also needs to reflect on how to understand patients' sayings. Is their view a correct interpretation of happenings? Is it distorted, and if so, how? Yet, their subjective experience needs to be taken seriously.

Rapley (2001) reminds us that in interviews participants can be concerned to present themselves in a positive way. Psychoanalytic theory, furthermore, tells us that not only can we - and patients - consciously decide to present ourselves in a given way, but unconscious factors can also play a role. "To a large extent, we are characters living out a script written by the unconscious" (Gabbard 2005b: 12). Conscious and unconscious reasons can lead to a distortion of facts. Certain facts can be triangulated, for example how regular a registrar is seeing his or her patients – such information can be gleaned from interviewing the patient and from examining the patients' files. Other facts cannot be triangulated, for example how good the relationship was between registrar and patient, how well he or she listened, how he or she responded. Here the patient's word has to be accepted. Or not? What about an overinvolved registrar with no sense for a frame or boundaries, one who contributes to splitting in the team, but is seen in positive terms or even idealised by the patient? When reviewing data, limitations such as these should be kept in mind.

#### **10.2.4 Peer reviewing**

I discussed the research process and the data gathered on a very regular basis with my supervisor, Professor Krüger. She was in an ideal situation for this role of peer debriefing, since she is a Consultant Psychiatrist at WKH, and also the Head of Research, Department of Psychiatry, University of Pretoria. We usually had weekly meetings, lasting from 60 to 90 minutes, in which we reviewed the data and models and discussed how to proceed. She also separately coded four of my interviews to check my way of coding the data.

### **10.2.5 Thick descriptions**

The setting, participants and themes were described in its complexity, but most importantly the participants were quoted verbatim and in great detail. The detail of the descriptions should enable the reader to get a feeling for the patients and a better understanding of the situation.

### **10.2.6 Member validation**

I discussed and clarified with participants during follow-up interviews whether my understanding and quotes as stated in the transcriptions and field notes were accurate reflections of the participant's points of view.

## **10.3 SUMMARY OF CHAPTER 10**

Both case study as well as insider research were not a negative in my study, but contributed in a positive way to help me gain more insight into the topic of my research. I used six different methods to establish trustworthiness and to assure the goodness of this study. Creswell (2013) suggests that a researcher uses at least two.<sup>55</sup> I am therefore of opinion that the goodness of the study was assured by the different criteria I followed to establish trustworthiness.

I defined crystallisation in a new way and brought in the psychoanalytic concept of triangulation and the marrying of the psychoanalytic concept of triangulation and crystallisation.

---

<sup>55</sup> See Section 2.8

## **SECTION 4**

### **CONCLUDING NOTES**

**In this section:**

**Chapter 11: Summary, implications and recommendations**

**Chapter 12: Personal reflections**

## 11 SUMMARY, IMPLICATIONS AND RECOMMENDATIONS

### 11.1 INTRODUCTION

In this chapter I present and discuss the following:

- A summary of the study, the findings and the methodology used
- Ethical problems flowing from the study
- Key contributions and implications
- Recommendations coming from my findings and model developed
- Limitations and future research

### 11.2 A SUMMARY OF THE STUDY AND THE FINDINGS

The reason why I embarked on this study was to understand in which way or how our registrars engage with the patients in the hospital. Do they form therapeutic relationships? If not, do patients miss this? Do patients form other relationships? From this understanding I wanted to develop a model and substantive theory of therapeutic relationships in a psychiatric hospital.

The thesis is divided into four sections. **Section 1** is about the study and its methodology (Chapters 1 and 2) and **Section 2** on the findings (Chapters 3 to 7). **Section 3** consists of the literature review, followed by a description of the model and substantive theory of therapeutic relationships in a psychiatric hospital and an analysis of the trustworthiness and goodness of the study (Chapters 8 to 10). **Section 4** consists of the concluding notes (Chapters 11 and 12).

**Chapter 1** consists of the background and context of the study. I briefly sketched the challenges mental health in South Africa faces and gave an overview of the training programme of our registrars. In this I included their academic activities and services to patients. I also discussed the purpose of the study, the research question, aim and objectives. Furthermore, I described my personal interest in the study and my different roles in Weskoppies Hospital (WKH). I also mentioned anticipated contributions of this study.

In **Chapter 2** I described qualitative research as the research approach of this study. To this I added a description of my research philosophy and my view of the place of literature and theory in qualitative research. I also discussed grounded theory and elaborated on the analytic procedures and coding used in grounded theory. I focussed on a description of inductive and abductive reasoning, since these are of central importance in qualitative research.

This was followed by a discussion of research ethics, my research design, and what a case study is. I ended with describing my research methodology, the key steps I took in the research process and the strategies I used to ensure quality.

**Chapter 3** starts with an introduction to WKH and the admission process, as well as the 15 patients who participated in the study. Mulling over the data and trying to make sense of it led to the development of several models to represent the information gathered. In this process the concept of ‘containment’ became of central importance to me. There is no therapeutic relationship without containment. I also considered the complexity of the situation and that whatever happens in a hospital cannot be seen in isolation, but is part of a huge inter-related system.

A good experience was that none of the patients I approached refused to participate. Most were actually eager to participate. During the interviews with the patients I however noticed how cold and sterile most of the wards are; the closed wards reminds one of a prison.

**Chapter 4** consists of an overview of the initial experiences in the hospital. Participants describe their experiences of the admission process and of the situation in the different types of wards. Most patients described very difficult experiences in closed wards leading to feelings of helplessness. Even in open wards some patients experienced intense feelings of loneliness. I recounted the story of one such patient.

Unfortunately, unacceptable violations of privacy and human rights were also described by a few patients.

In **Chapter 5** I described positive and negative interactions between patients and the different members of the MDT. I also included interactions between patients and fellow patients, patients and cleaners and patients and medical students. Interesting are the various forms relationships with fellow patients can take and how fellow patients can be role models and even a source of hope.

The studying of the hospital files was disappointing, little information is given about the personal life of the patient. It left me with the question of who this patient is. Hopefully much more happened between registrar and patient than what was recorded in the file.

In **Chapter 6** I described other factors of containment. Family and friends, but also religion, spirituality, culture and language can play an important role in providing containment and thus assist in the care and treatment of patients. To further the therapeutic alliance it is important for the treating doctor to understand the culture and preferably to also speak the language of the patient.

Family and/or friends can have a destabilising influence on the patient if they become critical and condemning. This could be due to having little understanding of psychiatric illnesses, or as a consequence of their own inner conflicts.

**Chapter 7** deals with the importance of the therapeutic relationship. I quoted patients emphasising the value of this relationship. For them it was a source of hope, or something that stimulated personal growth. Patients also want to be known personally.

I then addressed factors that influence the development of such a relationship. One of these is the challenging situation in the medical field in South Africa, especially in mental health, with a serious lack of resources and manpower. The question is how a therapeutic alliance can develop in such circumstances?

**Chapter 8**, the literature review, is focussed on the theme of relationships. I started with musings about the ideal situation in a hospital and about mental health, then I turned to the reality of being a psychiatric patient and the difficulties staff members have to deal with. I described forced treatment and measures of containment or control of patients. I also

discussed various models of healthcare, ending with the bio-psycho-social-spiritual model and a person-centred approach. This led to a discussion of various aspects of a relationship and of a therapeutic relationship. I ended with discussing certain aspects of the training of registrars.

In **Chapter 9** I gave a summary of the most salient findings with the patients. I described different types of encounters in the hospital, followed by a discussion of containment and the MDT. I then gave a description of the seventh model; this included mapping out the different aspects and people involved in this model and theory of therapeutic relationships. I also discussed obstacles in the realisation of a therapeutic relationship and that only about 20 per cent of patients in my study had such a relationship.

**Chapter 10** is an analysis of the trustworthiness and goodness of the study. I discussed concerns about case study, as well as insider research, and strategies I used to assure quality.

The final section of the thesis, Section 4 contains two chapters.

In this chapter, **Chapter 11**, I give a synopsis of the study. I then discuss ethical problems flowing from the study. I also outline the key contributions and implications of the research findings, the conclusions reached and recommendations made. The limitations of the study are also mentioned.

**Chapter 12** comprises my personal reflections on the doctoral journey.

### 11.3 ETHICAL PROBLEMS FLOWING FROM THE STUDY<sup>56</sup>

In the closed wards some patients described standing naked in a row, waiting to shower. In the evenings they had to undress in front of fellow patients, as well as nursing staff. This lack of privacy was described as very upsetting. The sharing of tooth brushes is also, for obvious reasons, unacceptable.

---

<sup>56</sup> See Section 4.7.

Physical violence, according to several patients, also occurred in closed wards - aggressive patients and nursing staff members would hit each other. Patients said that staff would beat and kick patients.

One patient described being put into seclusion, without access to toilet facilities, for two to three days. She stated that other patients were put naked into seclusion for some time.

I discussed these allegations with my supervisor and the first step we took was to advise the patients to write letters, anonymously if they wished, to the Complaints Committee of the hospital (of which I am the chairperson and on which the CEO and the Director of Nursing also sit). The CEO's reaction was commendable and not at all defensive. The Complaints Committee had these allegations investigated. The outcomes of these investigations are described in the following paragraphs.

The incident with the patient having been in seclusion for a long time could only have happened many years ago. Putting a patient into seclusion is strictly regulated, for many years national protocols have had to be adhered to and the time in seclusion is kept to a minimum. (I do not have information about the average length of seclusion.) The regulations stipulate the need for a doctor to order seclusion and the frequency of observations. All rooms also have toilet facilities.

Toothbrushes were actually shared. After these complaints were examined, the system was changed; toothbrushes are now marked and each patient uses his or her own toothbrush.

Violent behaviour by staff did unfortunately occur at times. The CEO informed me that the Head of the Department of Psychology had already been tasked with drawing up a more extensive training programme for nursing staff; there is an awareness that nursing staff need support and further training to be able to treat difficult patients in acceptable ways. But, as indicated by me in Sections 9.5 and 9.6, in my opinion this alone will not solve the issue; the contribution to this problem by *all* parts of the system have to be addressed, as this is part of a systemic problem. It is wrong to only blame nursing staff - or any other

team members, or management of the hospital - and to not look at this problem from a systems point of view.

The system I am referring to includes:

- Weskoppies Hospital and all its staff members
- The Medical School of the University of Pretoria
- The National Department of Health.

By writing this I am not implying that every person that is part of this system in WKH should not also look critically at his or her own contribution to our problems and should ask him- or herself how they can contribute to improving the situation.

These allegations were thus addressed, but ongoing monitoring is necessary to prevent future violations of patients' rights. A committee should be set up by the hospital (see recommendations, Section 11.5.2) to monitor happenings in closed wards. If, in spite of the measures taken by the management of the hospital, such incidences happen again, these should be reported to the Mental Health Review Board in terms of the Mental Health Care Act, No 17 of 2002.

#### **11.4 KEY CONTRIBUTIONS AND IMPLICATIONS**

In my research I developed several ideas, concepts and validation strategies that can help with:

- Understanding the complexity of the system we work in.
- The training of registrars.
- Helping with service delivery to patients.
- Enhancing the quality of qualitative research.

These important contributions stemming from my PhD project are:

## **11.4.1 Theoretical contributions**

### **11.4.1.1 A model and substantive theory of therapeutic relationships**

The first important contribution of my research is the development of a model and substantive theory of therapeutic relationships in a psychiatric hospital and its possible impact on the training of registrars.

My seventh model and substantive theory of therapeutic relationships makes it clear that we have to include systems theory<sup>57</sup> in thinking about this topic. Systems theory emphasises reciprocity and shared responsibility. The perspective is holistic, with the focus on the processes and context that give meaning to events, instead on individuals or events in isolation (Becvar and Becvar 1996). Processes emerge from the interaction of the parts and are more than just a characteristic of individual parts. For a proper assessment of the situation in WKH we have to consider the interaction between all the different people and forces involved.

The recommendations flowing from this understanding are listed in Section 11.5.

### **11.4.1.2 Containment as key concept<sup>58</sup>**

The second important theoretical contribution of my study is the introduction of the psychoanalytic concept of containment into psychiatry. It could be argued that containment should not be listed separately, but that it is part of a therapeutic relationship. I want to list it separately, because to me it is such an important concept. Another reason is that there are therapeutic relationships in which containment does not play a (prominent) role, for example with higher functioning patients who have an inner sense of security.

For our patients, suffering mostly from severe mental illness and having insecure or disorganised attachment patterns<sup>59</sup>, containment<sup>59</sup> is of utmost importance, not only in formal psychotherapy, but in the general interaction with the patient.

---

<sup>57</sup> Refer to Section 8.3.2 for a discussion on systems theory.

<sup>58</sup> I discussed containment in Section 8.4.7.

‘Measures of control’ are well-known in psychiatry, but there is little knowledge or understanding of the concept of containment through the connection with a person.<sup>60</sup> What Casement (2006: 82) writes about psychoanalysis is also applicable to psychiatric care in a hospital: “We have to find ways of containing a patient through words, and through the nature of our attitude and presence in a session, without having to resort to physical measures.”

For our service in WKH the question is: How can we help patients, even in closed wards, through words, through the nature of our attitude towards them, and through our presence in the session? Attention to these aspects, as well as seeing the patient more regularly and not only once a week and keeping the patient well informed about the treatment programme can lessen problems. Understanding containment means that there will also be an understanding of the importance of boundaries and ‘the frame’ in any interaction.<sup>61</sup>

I am not saying that all patients can be contained in such a way. A holistic approach is always indicated and this might include the use of medication and/or other measures of control.

#### **11.4.1.3 Shortcomings in the training of registrars**

A third theoretical contribution is highlighting shortcomings in the training of registrars in person-centred psychiatry.<sup>62</sup>

My impression of the situation in the Department of Psychiatry, WKH, is that the training in biological psychiatry and in doing research ranges from very good to excellent. Not enough emphasis is, however, placed on a person-centred approach, where the whole person and not the disease is at the centre of health care. According to Shapiro (2012) the pressures of the healthcare system in the USA have pushed registrars to learn to manage their patients rather than listen to them. In our system the pressure is probably worse, with

---

<sup>59</sup> I discussed attachment theory in Section 8.4.3.

<sup>60</sup> I discussed containment vs. ‘measures of control’ in Section 9.3.

<sup>61</sup> Boundaries and the frame I discussed in Section 8.5.3.

<sup>62</sup> I elaborate on this in Section 11.5.2.1.

as result that our registrars practice a similar approach. Our registrars follow a mostly biological, symptom-focussed approach and therapeutic relationships are seldom established.

#### **11.4.1.4 Three strategies for ensuring quality and trustworthiness in qualitative studies**

My fourth theoretical contribution is the introduction of three concepts or ideas to the establishment of trustworthiness and quality in qualitative research.<sup>63</sup> They are:

- i. A new definition of crystallisation.
- ii. Adding the psychoanalytic idea of triangulation to the traditional idea of triangulation.
- iii. Marrying of the psychoanalytic concept of triangulation with the concept of crystallisation.

For me crystallisation became a central concept. I described it as an active form of waiting, which allows truths to crystallise. In my opinion crystallisation should be a central procedure for establishing trustworthiness in qualitative research.

### **11.4.2 Methodological contributions**

#### **11.4.2.1 Qualitative research**

Most research in psychiatry is of a quantitative nature. This qualitative study can stimulate interest amongst registrars or psychiatrists in qualitative research. Especially registrars, who have to complete a research project as part of their studies, might recognise the value of a qualitative approach to their research.

---

<sup>63</sup> See Section 10.2.3.

### **11.4.2.2 Combining a case study approach with methods of analysis stemming from grounded theory**

Another interesting aspect of this study was to combine a case study approach with methods developed in grounded theory to analyse and synthesise the data. This combination worked well and helped me to give a good description of the world of the hospitalised psychiatric patient and to develop a model and theory of therapeutic relationships in WKH.

### **11.4.3 Practical contribution or value of the study**

Another contribution of my study is to highlight that patient care should come first and that registrars should focus more on this.

Psychiatrists and registrars are so-called joint appointees. This is the case with most medical personnel appointed at the universities in South Africa and means that doctors are appointed by both a university and the government. The implication of such a joint appointment is that such personnel are tasked with:

- Training of under- and postgraduate medical students
- Research
- Service delivery to patients.

Being a joint appointee leads to a certain conflict of interest: the government wants service delivery, the university research and training.

Interpreting the results of my study I am of opinion that patient care needs more attention in WKH. Registrars usually have short consultations with patients once a week and patients are only seen more than once a week if there are specific problems with a patient. (Although some patients are also seen by the intern-psychologist and the OT.) Once-a-week consultations have however been the pattern of doing things for decades. I thought

about my time as a registrar in the same hospital more than 20 years ago - the load was so heavy that at times it was for me only about emotional survival.

From a certain point of view it could be said that the relationship between the academic programmes vs. patient care is skewed in our department and that patient care comes second in WKH and is fitted into the time remaining after the academic programme has been attended to. This is a catch-22 situation. Proper training is expected from an academic institution, but proper training cannot be done without proper care to the patients. For example, seeing a patient with a major depressive disorder once a week is not good care. Most registrars and other staff members try to deliver a good service, but the different tasks at hand are just too many. (I have mentioned in Section 1.2 that in certain teams a registrar can have 25 to even 35 inpatients.) Therefore, to improve the service delivery more registrar posts need to be created.

Noteworthy is that there are some registrars who, even in this difficult situation, practice a person-centred approach and who even stay after hours to see their patients. How do they cope?

I discussed this problem recently with two senior registrars. They echoed my own experience and said the pressure was so intense that they only do what is necessary. "Seeing a patient once a week is the accepted norm, so as a registrar you don't reflect any further on this." Follow up consultations are often short and orientated towards present complaints. "You are emotionally under pressure, so you only do what is required, you are only emotionally engaged according to what the rules and the situation allow you, which means that there is a certain emotional distance between you and the patients. You follow the pattern of how things are done, because then you are 'safe', no one can point a finger at you and you don't reflect about what the situation is for patients. The academic pressure is very intense, in the afternoons you try to get home as soon as possible to prepare for the next academic activity." The combination of academic work and patient load is just too much. (The two registrars read what I had written about our discussion, agreed that it was a correct rendering and that I could cite them in my thesis.)

Young psychiatrists, used to seeing patients once a week under time pressure, have problems adjusting to a situation in private practice, where in-patients are usually seen six times a week. As discussed in Section 9.2.4 they often “run out of words”, some (probably most) feel helpless faced with such a situation and they stay with a symptom-orientated approach in their patient-doctor interaction, a managing of patients.

Is it good training if registrars have an excellent knowledge of theory, but are used to these practices in WKH? What would lead them to change such an ingrained pattern later in their career? This shows an important limitation in the training offered at WKH due mainly to difficult circumstances.

The practical contribution is to highlight the problem of patient service delivery and to bring to attention the urgent need to create more posts for registrars and to thus appoint more doctors, since with the present ratio of registrars/psychiatrists to patients in the public sector a person-centred approach is often not possible.

#### **11.4.4 Summary of contributions**

In summary, my psychoanalytic background informed this study. This, and the many years of focussing on patient care, helped me in thinking about this research project. I brought new ideas to this topic as well as to validation strategies. I also highlighted that patient care is not and cannot be what it should be in the present problematic situation of healthcare in the public sector in South Africa. The pressure on registrars is just too much and, to not jeopardise training standards, the only real answer is to appoint more registrars. The practical value of the study is to bring this to an awareness and to stimulate thoughts about changing this situation.

## **11.5 RECOMMENDATIONS**

### **11.5.1 Recommendations to provincial management**

For a better service to patients, the ratio of staff to patients has to be addressed; with the present situation service delivery will remain strained. More staff, especially registrars, need to be appointed. But, as pointed out by Burns (2010), mental health in general needs to be prioritised.

### **11.5.2 Recommendations to hospital management**

More organised daily inpatient programmes are needed, especially in closed wards. The present situation leads to a lot of frustration with many negative consequences. Psychologists, OTs and social workers need to help with the development of such programmes or rehabilitative schedules. These could include group psychotherapy, as well as groups on a wide range of topics, such as psycho-education, the consequences of substance abuse, communication skills, life skills, etc. This would also help to ensure that patients are locked up for less hours each day, as it is unacceptable that patients are locked into their dormitories for so many hours per day.

More organised activities and more individual attention to patients should lessen the need to put patients into seclusion, an action that should be strongly discouraged and only used in extreme circumstances and if no other alternatives are available.

A committee should be set up to reassess present regulations about patients being in closed wards and where necessary draw up new regulations; these should include regulations about when patients can be sent to closed wards and for how long. Seclusion policies need to be reviewed, as well as the hours patients are locked into their dormitories per day. This committee should also in an ongoing manner monitor whether any violations of patients' rights occur, including violation of the privacy of patients; if such violations happen again, further action needs to be taken as mentioned in Section 11.3.

The role that nursing staff play in the treatment of patients should be reassessed; they have a lot to offer. Although meaningful interactions with patients do happen, this is at times still limited and more interaction could be encouraged. Training programmes for nursing staff are in place, but could be reassessed in terms of whether enough attention is given to a person-centred approach.

### **11.5.3      Recommendations to the Department of Psychiatry, UP, and the College of Psychiatrists of the CMSA, South Africa**

Although the College of Psychiatrists of the Colleges of Medicine (CMSA) has extensive requirements for training in psychotherapy, which can be found at [http://www.collegemedsa.ac.za/view\\_exam.aspx?examid=41](http://www.collegemedsa.ac.za/view_exam.aspx?examid=41), the emphasis is still on a biomedical approach in both the public and private sector. As part of a person-centred approach, psychotherapy and the training thereof needs to be given more status and priority. Training in both individual and group psychotherapy should receive much more emphasis than at present, much more depth is needed in this training. The College of Psychiatrists' subcommittee should look into this matter and monitor training on an ongoing basis, with the long-term goal of establishing psychotherapy as a registered sub-speciality.

Group psychotherapy is a valuable tool, especially in situations where there is a shortage of therapists. To act as co-therapists in such groups would be an invaluable experience for registrars.

Training in psychodynamic theory and the ability to draw up a psychodynamic formulation should be emphasised. As described by Shapiro (2012), such training can help registrars to learn to listen to the unique problem a patient is struggling with. It teaches thus a person-centred approach. Thinking in a psychodynamic way and creating such a formulation does not mean that the psychiatrist will necessarily work in a psychodynamic therapeutic way with the patient. The psychodynamic formulation is primarily an attempt to reach a better, holistic understanding of the patient, which then can be used in different ways; it can serve as a guide in the development of a treatment plan, for example

cognitive behaviour therapy or pharmacotherapy, and to predict how the patient might interact with the psychiatrist or respond to being prescribed medication (Böhmer 2011).

Such training should also attend to skills in communicating and interacting with patients and the ability to become aware of and to reflect about problematic situations that develop, for example, in the interaction of registrars with patients and with the MDT.

Registrars' focus on and abilities to establish containing therapeutic alliances should be assessed during supervision of their psychotherapy patients, but also by the consultants during registrars' rotation at the various teams.

#### **11.5.4      Recommendations about the selection of registrars**

One of the problems psychiatry face, linked to the ascendancy of biological psychiatry, is the belief by some that we need to train psychiatrists who are knowledgeable in this model only, psychiatrists who can diagnose and prescribe according to a system based on the detection of symptoms. Compare this with Roger's (1961) statement<sup>64</sup> that in this type of work knowledge alone is not enough, but that it also depends on the maturity and wisdom of the therapist or doctor. More than knowledge in biological psychiatry is needed. According to Rogers (1961) the degree to which I can create relationships, which facilitate the growth of others as separate persons, is a measure of the growth I have achieved in myself. (Noteworthy is that one patient said the absence of a therapeutic relationship blocked him from growing.<sup>65</sup>)

I want to link this with Symington's openness about his mental problems. When Symington wanted to start training as a psychoanalyst<sup>66</sup>, he was interviewed by a selection panel consisting of three psychoanalysts, who did not realise that Symington suffered from considerable psychological problems. Fortunately his training analyst did and insisted on analysis *before* he started his training. Only after three and a half years of psychoanalysis/psychotherapy did Symington enter the training programme.

---

<sup>64</sup> See Section 8.6.4.

<sup>65</sup> See Section 7.1.

<sup>66</sup> See Section 8.6.4.

Why do we accept candidates for a registrar post after a 20 - 30 minute interview? What is their level of maturity and inner stability? And what do we do to assess their functioning once they are in the programme? What help do we provide them to grow as persons? These are questions for the Post-graduate Committee to look into.

## **11.5.5 Concrete suggestions specific to the situation in WKH**

### **11.5.5.1 General recommendations about the interaction between registrars and patients**

If a person-centred approach and the establishment of therapeutic relationships is a goal, then the following needs to be attended to:

- Registrars should stay involved with their patients over a longer period of time. Previously registrars rotated between teams on a six-monthly and not four-monthly basis. The Post-graduate Committee should again review this to decide which option is the better one. Obviously, this also has to be feasible.
- Hospitalised patients should be seen at least twice a week. The second consultation could be a short visit to check on the condition of the patient.
- The consultations with the patients should, where possible, be according to a predetermined schedule. This means that a patient will know that he or she will, for example, be seen by the registrar every Tuesday and Friday. This forms part of the frame, provides support and helps to build a therapeutic relationship.
- Consultations should be more than just symptom-focussed; the focus should be on the patient as person.
- If students are present, the patient needs to be prepared for this and also asked whether an additional private session with the registrar is needed.
- The presence of students might be easier for a patient if it is the norm for students to also see the patients on their own. If the students have already met the patient and established a connection, a session together with the registrar will be much easier for all involved.

### **11.5.5.2 Registrar allocations to the teams and allocations of wards**

Two registrars are allocated to each team in WKH, this should when possible, consist of one senior and one junior registrar. The reason for this would be to try and prevent situations in which registrars of one team write examinations at the same time, which would allow for more consistency in the care of the patients of each team. (This is already usually, but not always, done.)

Registrars I spoke to said that it would help them if a specific ward could be allocated to a registrar. At present, a registrar's patients are scattered through several wards, which makes it more difficult to arrange follow-up visits. It would be easier to arrange this with one or two wards, the interaction with nursing staff would also improve. If one registrar is in charge of a closed ward, it might also shorten the time patients spend in such wards. The feasibility of this would have to be investigated.

### **11.5.5.3 The academic programme**

In my discussion with registrars they highlighted how little time is left for patient care. They felt this situation would improve if all academic discussions were fitted in on Fridays. This would however mean that the Monday Team, whose outpatient clinic is on Fridays, as well as the Friday Team, who are on call on Fridays, won't be able to participate. An alternative would be to hold all the academic discussions on Wednesday and Friday afternoons, to free up the other days for patient care. This is something the Post-graduate Committee could look into.

### **11.5.5.4 The out-patient clinics**

Previously the times for the out-patient clinics were from 8h00 – 12h30, but it was changed by management to 8h00 – 15h30. What happens now, I am told by registrars, is that patients trickle in any time of the day (they are not given specific times). The number of patients seen and the time spent on consultations remains more or less the same, but

registrars are now sitting at the clinic waiting for patients, whereas if the time was limited to only 8h00 – 12h30 it would free them to have more time for inpatients.

#### **11.5.5.5 Ward programme**

In the closed wards the routine is that patients are seen by the registrars with nursing staff present, there to give feedback about the patients. (Actually this way of doing things can also impair the development of therapeutic relationships.) Because breakfast is only served after 8h00 in the hospital, this means that patients are only seen from 9h00 onwards, since nursing staff are busy with their other duties until 9h00. An alternative allowing for an earlier start should be sought. Working hours are from 7h30 – 16h00. Registrars should be able to start much earlier in the wards.

#### **11.5.6 The role of the consultants**

I have mentioned that consultants do not really feature, patients did not mention them. The consultant psychiatrist is present at the weekly MDT meeting during which all patients are discussed, furthermore he or she is the leader of the weekly ward conference where one patient is presented in depth. Lastly, if registrars struggle with a patient for various reasons, the consultant psychiatrist will see this patient together with the registrar. Is this enough?

I cannot comment on how this should or could change, since the different consultant psychiatrists have different job descriptions; apart from their duties in their teams, some are also involved in forensic psychiatry, others see patients in peripheral clinics, or are more involved in the research activities of the registrars, or other teaching activities. But where possible, more interaction with the patients would be helpful. Perhaps the threshold for seeing difficult ward patients should be set lower. In my team I started a weekly meeting with patients in our wards.

Lastly, consultants are keepers of the frame as well as providers of containment for their teams. They should be aware of these functions and have the needs of their teams and its members in mind.

## **11.6 A FINAL ASSESSMENT OF THE SITUATION IN WKH**

Taking all the concerns into consideration, I think the data does indicate that registrars' interaction with their patients are, in general, limited. Most registrars have superficial interactions with most patients. The reasons for this are however complex, as discussed in Chapter 9. Certain registrars might want a more meaningful interaction, but the difficulties of the situation, such as their workload, might make this often impossible. The same applies to the other team members.

Systems theory emphasises reciprocity and shared responsibility. It is a mistake to blame only nursing staff if, for example, they beat patients in the closed wards. The whole MDT has to take responsibility and each member of the team has to ask him- or herself how they contribute to such a situation. If registrars would be able to see patients more regularly, it would lead to less acting out by patients. If psychologists were present in the ward more regularly, patients would feel more cared for. If OTs organised more activities, this could help to lessen aggressive acts.

But is it fair to point fingers at the staff of WKH? Do outside factors not play a bigger role? What about the socio-economic and political situation? These factors do play a major role and the above-mentioned activities and regular visits will only be possible if politicians agree to appoint more staff and allocate more funds to mental healthcare.

## **11.7 LIMITATIONS AND FUTURE RESEARCH**

One of the limitations of this research is that I did not focus on intercultural and interracial issues. This is of great importance, especially in South Africa. I refer the reader to Section 8.5.7 in the literature review, where I gave a short introduction into this topic.

Another limitation is that religious and spiritual aspects of mental illness were not directly addressed in the questionnaire and thus received limited attention.

A third limitation is the question of whether the renderings of patients can be believed. I have already discussed how to approach this problem. In this, I highlighted that the study was informed by my psychoanalytic background and that this helped me in approaching the question of the veracity of patients' accounts.

A fourth limitation is that this research was limited to one psychiatric hospital, WKH.

Future research could focus on:

- Intercultural and interracial care and how this influences therapeutic relationships.
- Religious and spiritual aspects of mental health and illness.
- How young psychiatrists manage the transition to private practice and what they focus on.
- Shortcomings in the training of registrars.
- Many aspects of therapeutic relationships are still not clear, as highlighted by my research. For example, why do patients form relationships with certain patients? Here, I am thinking about the interaction between the young psychology student and the elderly patient who at times responded in an inappropriate way. Or patients who act inappropriately yet are role models.
- Research on this or similar topics could be done in other psychiatric hospitals in South Africa to confirm or disconfirm the results of this study and to compare training programmes at the different universities.

Publications that could flow out of this study are:

- A general summary of this study.
- Methods to establish trustworthiness in a qualitative study.
- How to intervene ethically in improving the care and treatment at WKH.
- What change is needed? Designing a systems informed model of care and treatment in WKH in order to stimulate the development of therapeutic relationships.

## 12 PERSONAL REFLECTIONS

I joined the Department of Psychiatry, University of Pretoria, at a relatively late stage in my life. There are disadvantages, but also advantages to such a situation. The advantages are that I have had many experiences in life, also years of experience in focussing on the treatment of patients, especially through psychotherapy, and furthermore of reading widely. Doing a PhD was not something I initially had in mind, but looking back I am glad to have embarked on such a journey. It has been a privilege to do this for several reasons:

- The study helped me to gain a better understanding of the situation hospitalised psychiatric patients are in.
- Focussing for a long time on the topic of the different aspects of relationships was enriching.
- Doing a PhD helps ‘to structure one’s mind’, to establish new categories and ways of thinking.
- I do hope that this thesis will make a contribution to the care of our patients and the training of registrars.

There were however also difficult times, during which I found it hard to continue. I cannot link these difficult times to specific phases of the study; for example, what I had feared the most, the literature review, turned out to be one of the most interesting phases. But the PhD took over my life and I was busy with this project seven days a week. This is probably a main reason why I did not do it earlier.

When I started to think about doing a PhD, I initially could not come up with an appropriate topic. I did not want to focus on a topic that did not really interest me and came up with ideas that I would now describe as totally unfeasible. I felt too stupid to formulate an appropriate research question, even after many discussions with various people in different fields of study. Only after the workshop with Professor Willem Schurink was I able to come up with this idea.

When I did start with the study I came across many stumbling blocks, but found even more helpful people. The patients were also helpful. Upsetting to me and my supervisor was

some of the information I got from them, especially about ethical violations. It caused me many inner conflicts and also led to an inner attitude of negativity at that stage towards Weskoppies Hospital (WKH). I thought back about the time in private practise, the excellent facilities of the private psychiatric hospitals and that I could usually determine how much time I could or should spend with a patient.

Developing the models of containment and therapeutic relationships helped me to think how we all contribute to the situation in WKH, and more importantly, how we are to a certain degree victims of a situation in which mental healthcare is neglected and does not receive the necessary funds and support from government. Instead of pointing fingers at different staff members in WKH we should rather admire the fact that people are willing to do this work under difficult circumstances and with patients suffering mostly from severe mental illness. Registrars also receive training - in these difficult circumstances - that in many aspects is very good. And yet, what a difference it would make to patients if more was invested in mental health care. It could alleviate so much suffering.

To be able to contain whatever is happening can be challenging in such a situation. As head of the Team for Mood and Anxiety Disorders (the 'Monday Team') I realise this every Monday morning during our MDT meeting: We, the team, are confronted with so many problems that it is difficult to not act out, but to remain calm and to do what is possible.

So many things our patients said are worth pondering about. I want to highlight a few thoughts at the end:

- Medical doctors rely so much on the biological aspects of treatment and often believe that this is what helped or not. Meanwhile the patients often focus on interpersonal happenings and the personal qualities of helpers and these factors play a big role in the outcome of treatment.
- Talking and connecting is so important.
- The role of nursing staff is undervalued by others and by nurses themselves.
- To train a good doctor theoretical knowledge alone is by far not enough. What is the use of all of that, if they don't know how to speak to a patient or how to build a therapeutic relationship?

Throughout this thesis my critical attitude towards certain aspects of modern medicine should be clear. But, having recently been on the ‘wrong side’ of an operating table, I am extremely grateful for the technical developments in medicine and would myself rather see a good surgeon-technician, than a bad surgeon widely educated and with good interpersonal skills. The outcome in many fields of medicine is, however, influenced by the doctor-patient relationship. To neglect it is a mistake. The ideal would obviously be if these qualities can be combined in one person. The eminent biologist Wilson (2014), who taught at Harvard University for four decades, writes that studying the relations between science and the humanities should be at the heart of liberal education everywhere and for both students of science and the humanities alike.

Is this too much to ask for?

## REFERENCES

- Aldao, A., Nolen-Hoeksema, S. & Schweizer, S. 2010. Emotion-regulation strategies across psychopathology: A meta-analytic review. *Clinical Psychology Review*, 30(2): 217-37. <http://dx.doi.10.1016/j.cpr.2009.11.004>
- Archer, E. 2012. Introduction to ATLAS.ti. Guidance, tips and tricks to facilitate analysis & professional presentation. [Internet]. 4<sup>th</sup> ed. [cited 2013 Jul]. Available from: [http://school-maths.com/m\\_d/thesis/Atlas+Manual+4th+Ed.pdf](http://school-maths.com/m_d/thesis/Atlas+Manual+4th+Ed.pdf)
- Argyle, M. 1972. *The psychology of interpersonal behaviour*. Harmondsworth: Penguin.
- Atkinson, P. & Delamont, S. 2005. Analytic perspectives. In Denzin, N.K. & Lincoln, Y.S. eds. *The Sage handbook of qualitative research*. 3<sup>rd</sup> ed. Thousand Oaks, CA: Sage. p. 821-40.
- Bach, S. 2001. On being forgotten and forgetting one's self. *Psychoanalytic Quarterly*, 70, 739-56.
- Baker, J. 2000. Developing psychosocial care for acute psychiatric wards. *Journal of Psychiatric and Mental Health Nursing*, 7, 95-100.
- Balbernie, R. 1997. Containment and contentment. *Journal of Child Psychotherapy*, 23, 245-53.
- Balint, E. 1985. The history of training and research in Balint groups. *Psychoanalytic Psychotherapy*, 1(2): 1-9.
- Balint, M. 2002. The crisis of medical practice. *American Journal of Psychoanalysis*, 62, 7-15.

Bamm, P. 1968. *Ex ovo. Essays über die Medizin*. Stuttgart: Droemer Knaur.

Barker, P. & Cutcliffe, J. 1999. Clinical risk: A need for engagement not observation. *Mental Health Practice*, 2(8), 8-12.

Barker, D.A., Shergill, S.S., Higginson, I. & Orrell M.W. 1996. Patients' view towards care received from psychiatrists. *British Journal of Psychiatry*, 168(5), 641-6.

Barker, D.A. & Orrell, M.W. 1999. The psychiatric care satisfaction questionnaire: A reliability and validity study. *Social Psychiatry & Psychiatric Epidemiology*, 34, 111-6.

Barrie, J.M. 1911. *Peter Pan*. London: Everyman.

Bateman, A., Brown, D. & Pedder, J. 2010. *Introduction to psychotherapy. An outline of psychodynamic principles and practice*. 4<sup>th</sup> ed. London: Routledge.

Becvar, D.S. & Becvar, R.J. 1996. *Family therapy. A systemic integration*. 3<sup>rd</sup> ed. Boston: Allyn and Bacon.

Bellini, L.M., Baime, M. & Shea, J.A. 2002. Variation of mood and empathy during internship. *JAMA*, 287, 3143-6.

Bellini, L.M. & Shea, J.A. 2005. Mood change and empathy decline persist during three years of internal medicine training. *Academic Medicine*, 80, 164-7.

Bergman, M.M. & Coxon, A.P.M. 2005. The quality in qualitative methods. [Internet]. Forum: Qualitative Social Research, 6(2), Art 34, [cited 2013 Jul]. Available from: <http://www.qualitative-research.net/index.php/fqs/article/view/457/974>

Bertalanffy, L. von. 1968. *General systems theory: foundations, development, applications*. New York: Braziller.

Bertram, G. & Stickley, T. 2005. Mental health nurses, promoters of inclusion or perpetrators of exclusion? *Journal of Psychiatric and Mental Health Nursing*, 12, 387–95.

Bettelheim, B. 1987. *A good enough parent. A book on child-rearing*. New York: Knopf.

Bion, W.R. 1962a. *Learning from experience*. New York: Basic Books.

Bion, W.R. 1962b. A theory of thinking. In Bion, W.R. *Second thoughts*. 1984. London: Karnac Books, p. 110-119.

Blatt, S.J. & Shahar, G. 2004. Psychoanalysis – with whom, for what, and how? Comparisons with psychotherapy. *Journal of the American Psychoanalytic Association*, 52, 393-447.

Blazer, D. 2012. Religion/spirituality and depression: what can we learn from empirical studies? *American Journal of Psychiatry*, 169, 10-1. <http://dx.doi.org/10.1176/appi.ajp.2011.11091407>

Böhmer, M.W. 2010. “Communication by impact” and other forms of non-verbal communication: a review of transference, counter-transference and projective identification. *African Journal of Psychiatry*, 13, 179-83.

Böhmer, M.W. 2011. Dynamic psychiatry and the psychodynamic formulation. *African Journal of Psychiatry*, 14, 273-7.

Böhmer, M.W. Person-centred psychiatry. In *The Oxford Textbook of Psychiatry – South African edition*. Oxford: Oxford University Press. Forthcoming 2015.

Bonner, A. & Tolhurst, G. 2002. Insider-outsider perspectives of participant observation. *Nurse Researcher*, 9(4): 7-19.

Bordin, E. 1979. The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, and Practice*, 16, 2252-60. <http://dx.doi.10.1037/h0085885>

Bordin, E. 1994. Theory and research on the therapeutic working alliance: new directions. In A.O. Horvath & L.S. Greenberg. eds. *The working alliance: theory, research and practice*. New York, NY: Wiley. p. 13-38.

Bowen, G.A. 2008. Naturalistic inquiry and the saturation concept: a research note. *Qualitative Research*, 8(1): 137-52. <http://dx.doi.10.1177/1468794107085301>

Bowers, L. 2006. On conflict, containment and the relationship between them. *Nursing Inquiry*, 13, 172–80.

Bowers, L., Alexander, J., Ryan, C. & Carr-Walker, P. 2004. Cultures of psychiatry and the professional socialization process: the case of containment methods for disturbed patients. *Nurse Education Today*, 24(6): 435-42.

Bowers, L., Simpson, A., Alexander, J., Hackney, D., Nijman, H., Grange, A. & Warren, J. 2005a. The nature and purpose of acute psychiatric wards: the Tompkins acute ward study. *Journal of Mental Health*, 14(6): 625-35.

Bowers, L., Simpson, A. & Alexander, J. 2005b. Real world application of an intervention to reduce absconding. *Journal of Psychiatric and Mental Health Nursing*, 12, 598–602.

Bowers, L., Alexander, J., Simpson, A., Ryan, C. & Carr-Walker, P. 2007. Student psychiatric nurses' approval of containment measures: relationship to perception of aggression and attitudes to personality disorder. *International Journal of Nursing Studies*, 44(3): 349-56. <http://dx.doi.10.1016/j.ijnurstu.2005.03.002>

Bowers, L., Haglund, K., Muir-Cochrane, E., Nijman, H., Simpson, A. & Van der Merwe, M. 2010. Locked doors: a survey of patients, staff and visitors. *Journal of Psychiatric and Mental Health Nursing*, 17, 873-80.

Bowers, L., Stewart, D., Papadopoulos, C. & DeSanto Iennaco, J. 2013. Correlation between levels of conflict and containment on acute psychiatric wards: the city-128 study. *Psychiatric Services*, 64, 423-30. <http://dx.doi.10.1176/appi.ps.201200328>

Bowlby, J. 1988. *A secure base: clinical applications of attachment theory*. London: Routledge.

Bowles, A. 2000. Therapeutic nursing care in acute psychiatric wards: engagement over control. *Journal of Psychiatric and Mental Health Nursing*, 7, 179–84.

Bowles, N., Dodds, P., Hackney, D., Sunderland, C. & Thomas, P. 2002. Formal observations and engagement: a discussion paper. *Journal of Psychiatric and Mental Health Nursing*, 9, 255–60.

Boyle, D., Dwinnell, B. & Platt, F. 2005. Invite, listen, and summarize: a patient-centered communication technique. *Academic Medicine*, 80(1): 29-32.

Breen, L.J. 2007. The researcher 'in the middle': Negotiating the insider/outsider dichotomy. *The Australian Community Psychologist*, 19(1): 163-74.

Britton, R. 2003. *Sex, death, and the superego*. London: Karnac.

Brown, J.B., Thorpe, C., Paquette-Warren, J., Stewart, M. & Kasperski, J. 2012. The mentoring needs of trainees in family practice. *Education for primary care*, 23, 196-203.

Bruster, S., Jarman, B., Bosanquet, N., Weston, D., Erens, R. & Delbanco, T.L. 1994. National survey of hospital patients. *British Medical Journal*, 309, 1542-9.

- Bruster, S., Chandola, T., Coulter, A., Jenkinson, C. & Richards, N. 2002. Patients' experiences and satisfaction with health care: results of a questionnaire study of specific aspects of care. *Quality and Safety in Health Care*, 11(4): 335-43.
- Buber, M. 1984. Ich und Du. In Buber, M. *Das dialogische Prinzip*. 5<sup>th</sup> ed. Heidelberg: Lambert Schneider.
- Burns, J. K. 2010. Mental health services funding and development in Kwa-Zulu Natal: a tale of inequity and neglect. *South African Medical Journal*, 100(10): 662-6.
- Burns, J.K. 2014. The burden of untreated mental disorders in KwaZulu-Natal province--mapping the treatment gap. *South African Journal of Psychiatry*, 20, 6-10. <http://dx.doi.10.7196/SAJP.499>
- Cape, J. 2000. Patient-generated therapeutic relationship and outcome in general practitioner treatment of psychological problems. *British Journal of Clinical Psychology*, 39, 383-95.
- Cardinal, M. 1993. *The words to say it*. London: The Women's Press.
- Casement, P. 1985. *On learning from the patient*. London: Tavistock.
- Casement, P. 1990. *Further learning from the patient*. London: Tavistock/Routledge.
- Casement, P. 2002. *Learning from our mistakes*. Hove: Brunner-Routledge.
- Casement, P. 2006. *Learning from life*. London: Routledge.
- Chapman, S.C.E. & Horne, R. 2013. Medication nonadherence and psychiatry. *Current Opinion in Psychiatry*, 26, 446-52. <http://dx.doi.10.1097/YCO.0b013e3283642da4>

Charles, C., Gafni, A. & Whelan, T. 1997. Shared decision making in medical encounter: what does it mean (or it takes at least two to tango). *Social Science & Medicine*, 44, 681-92.

Charmaz, K. 2005. Grounded theory in the 21<sup>st</sup> century. Applications for advancing social justice studies. In Denzin, N.K. & Lincoln, Y.S. eds. *The Sage handbook of qualitative research*. 3<sup>rd</sup> ed. Thousand Oaks, CA: Sage, p. 507-35.

Charmaz, K. 2006. *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage.

Cleary, M., Jordan, R., Horsfal, J., Mazoudier, P. & Delaney, J. 1999. Suicidal patients and special observation. *Journal of Psychiatric and Mental Health Nursing*, 6, 461–7.

Colleges of Medicine of South Africa. 2014. Fellowship of the College of Psychiatrists of South Africa. Structure and Fees for the Fellowship of the College of Psychiatrists of South Africa: FC Psych. (SA). . [Internet]. [cited 2015 Jan 5]. Available from: [http://www.collegemedsa.ac.za/view\\_exam.aspx?examid=41](http://www.collegemedsa.ac.za/view_exam.aspx?examid=41)

Colli, A., Tanzilli, A., Dimaggio, G. & Lingiardi, V. 2014. Patient personality and therapist response: an empirical investigations. *American Journal of Psychiatry*, 171(1), 102-8. <http://0-dx.doi.org.innopac.up.ac.za/10.1176/appi.ajp.2013.13020224>

Colliver, J.A., Conlee, M.J., Verhulst, S.J. & Dorsey, J.K. 2010. Reports of the decline of empathy during medical education are greatly exaggerated: a re-examination of the research. *Academic Medicine*, 85 (4), 588-93.

Coulter, A. & Cleary, P.D. 2001. *Patients' experiences with hospital care in five countries*. *Health Affairs*, 20(3): 244-52.

Creswell, J.W. & Miller, D.L. 2000. Determining validity in qualitative inquiry. *Theory into Practice*, 39(3): 124-30.

Creswell, J.W. 2013. *Qualitative inquiry and research design: choosing amongst five approaches*. 3<sup>rd</sup> ed. Los Angeles: Sage.

Crichton, J. 1998. Staff responses to psychiatric inpatient violence: an international comparison. *Psychiatric Care*, 5, 50–6.

Cruz, M. & Pincus, H.A. 2002. Research on the influence that communication in psychiatric encounters has on treatment. *Psychiatric Services*, 53, 1253-65.

Cunningham, D.J. 1998. Cognition as a semiosis: the role of inference. *Theory and Psychology*, 8(6): 827-40.

Curlin, F.A., Lawrence, R.E., Odell, S., Chin, M.H., Lantos, J.D., Koenig, H.G., & Meador, K.G. 2007. Religion, spirituality, and medicine: psychiatrists' and others physicians' differing observations, interpretations, and clinical approaches. *American Journal of Psychiatry*, 164, 1825-31. <http://dx.doi.10.1176.appi.ajp.2007.06122088>

Dack, D., Ross, J. & Bowers, L. 2012. The relationship between attitudes towards different containment measures and their usage in a national sample of psychiatric inpatients. *Journal of Psychiatric and Mental Health Nursing*, 19(7): 577 - 86. <http://dx.doi.10.1111/j.1365-2850.2011.01832.x>

Decaire, M.W., Bedard, M., Riendeau, J. & Forrest, R. 2006. Incidents in a psychiatric forensic setting: association with patient and staff characteristics. *Canadian Journal of Nursing Research*, 36, 68-80.

Del Canale, S., Louis, D.Z., Maio, V., Wang, X., Rossi, G., Hojat, M. & Gonella, J.S. 2012. The relationship between physician empathy and disease complications: an empirical

study of primary care physicians and their diabetic patients in Parma, Italy. *Academic Medicine*, 87, 1243-9. <http://dx.doi.10.1097/ACM.0b013e3182628fbf>

Del Piccolo, L., Danzi, O., Fattori, N., Mazzi, M.A. & Goss, C. 2014. How psychiatrist's communication skills and patient's diagnosis affect emotions disclosure during first diagnostic consultations. *Patient Education and Counselling*, 96(2): 151-8. <http://dx.doi.10.1016/j.jpec.2014.06.001>

Del Piccolo, L. Goss, C. & Zimmerman, C. 2005. The third meeting of the Verona Network on sequence analysis. Finding common grounds in defining patient cues and concerns and the appropriateness of provider responses. *Patient Education and Counselling*, 57, 241-4.

Del Piccolo, L. Mazzi, M.A., Goss, C., Rimondini, M. & Zimmerman, C. 2012. How emotions emerge and are dealt with in first diagnostic consultations in psychiatry. *Patient Education and Counselling*, 88, 29-35.

Delport, C.S.L. & De Vos, A.S. 2011. Professional research and professional practice. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. *Research at grass roots*. 4<sup>th</sup> ed. Pretoria: Van Schaik, p. 45-60.

Delport, C.S.L., Fouché, C.B. & Schurink, W. 2011. Theory and literature in qualitative research. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. *Research at grass roots*. 4<sup>th</sup> ed. Pretoria: Van Schaik, p. 297-306.

Delport, C.S.L. & Fouché, C.B. 2011. The qualitative research report. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. *Research at grass roots*. 4<sup>th</sup> ed. Pretoria: Van Schaik, p. 424-30.

Delport, C.S.L. & Roestenburg, W.J.H. 2011. Quantitative data-collection methods: questionnaires, checklists, structured observation and structured interview schedules. In

De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. *Research at grass roots*. 4<sup>th</sup> ed. Pretoria: Van Schaik, p. 171-205.

Denzin, N.K. & Lincoln, Y.S. 2005. Introduction: The discipline and practice of qualitative research. In Denzin, N.K. & Lincoln, Y.S. eds. *The Sage handbook of qualitative research*. 3<sup>rd</sup> ed. Thousand Oaks, CA: Sage, p. 1-32.

De Saint-Exupéry, A. 1974. *The little prince*. London: Piccolo.

De Vos, A.S. & Strydom, H. 2011. Scientific theory and professional research. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. *Research at grass roots*. 4<sup>th</sup> ed. Pretoria: Van Schaik, p. 28-44.

Di Pellegrino, G., Fadiga, L., Fogassi, L., Gallese, V. & Rizzolatti, G. 1992. Understanding motor events: a neurophysiological study. *Experimental Brain Research*, 91, p. 176-80.

*Dorland's Illustrated Medical Dictionary*. 1974. 25<sup>th</sup> ed. Philadelphia: Saunders.

Education and Training Unit for Democracy and Development. Batho Pele: Improving government service. [Internet]. [cited 2013 Jul 9]. Available from: <http://www.etu.org.za/toolbox/docs/govern/bathopele.html#principles>

Egan, G. 2002. *The skilled helper: a problem management and opportunity-development approach to helping*. 7<sup>th</sup> ed. Belmont, CA: Brooks/Cole.

Eichelman, B. 2007. Religion, spirituality and medicine. *American Journal of Psychiatry*, 164, 1774-5. <http://dx.doi.10.1176/appi.ajp.2007.07091483>

Engel, G.L. 1980. The clinical application of the biopsychosocial model. *American Journal of Psychiatry*, 137(5): 535-44.

Epstein, R.M., Hadee, T., Carrol, J., Meldrum, S.C., Lardner, J. & Shields, C.G. 2007. Could this be something serious? Reassurance, uncertainty, and empathy in response to patients' expressions of worry. *Journal of General Internal Medicine*, 22, 1731-9.

Erasmus, Z. 2010. Confronting the categories: equitable admissions without apartheid race classification. *South African Journal of Higher Education*, 24(2): 244-57.

Erikson, E. 1950. *Childhood and society*. New York: Norton.

Eriksson, P. & Kovalainen, A. 2008. *Qualitative methods in business research*. Los Angeles: Sage.

Falkenström, F., Granström, F. & Holmqvist, R. 2013. Therapist alliance predicts symptomatic improvement session by session. *Journal of Counselling Psychology*, 60(3): 317-28.

Fenner, P. 2011. Place, matter and meaning: extending the relationship in psychological therapies. *Health & Place*, 17, 851-57. doi: 10.1016/j.healthplace.2011.03.011

Fitzpatrick, R. 2002. Capturing what matters to patients when they evaluate their hospital care. *Quality & Safety in Health Care*, 11, 306.

Flyvbjerg, B. 2004. Five misunderstandings about case-study research. In Seale, C., Gobo, G., Gubrium, J.F. & Silverman, D. eds. *Qualitative Research Practice*. London: Sage, p. 420-34.

Fossey, E., Harvey, C., McDermott, F. & Davidson L. 2002. Understanding and evaluating qualitative research. *Australian & New Zealand Journal of Psychiatry*, 36, 717-32. <http://dx.doi.10.1046/j.1440-1614.2002.01100.x>

Fouché, C.B. & Schurink, W. 2011. Qualitative research designs. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delpont, C.S.L. *Research at grass roots*. 4<sup>th</sup> ed. Pretoria: Van Schaik; p. 307-27.

Fourie, W., McDonald, S., Connor, J. & Bartlett, S. 2005. The role of the registered nurse in an acute mental health inpatient setting in New Zealand: perceptions versus reality. *International Journal of Mental Health Nursing*, 14, 134–41.

Fraser, C. 1976. An analysis of face to face communication. In A.E. Bennett ed. *Communication between doctors and patients*. London: Oxford University Press.

Freud, S. 1910. Die zukünftigen Chancen der psychoanalytischen Therapie. In Freud, S. 1982. *Schriften zur Behandlungstechnik*. Frankfurt am Main: S. Fischer Verlag, p. 121-32.

Fromm, E. 1963. Medicine and the ethical problem of modern man. In Fromm E. 2004. *The dogma of Christ*. London: Routledge Classics, p. 140-56.

Frost, N., Nolas, S.M., Brooks-Gordon, B., Esin, C., Holt, A., Mehdizadeh, L. & Shinebourne, P. 2010. Pluralism in qualitative research: The impact of different researchers and qualitative approaches on the analysis of qualitative data. *Qualitative Research*, 10(4): 441-60. <http://dx.doi.10.1177/1468794110366802>

Gabbard, G.O. & Kay, J. 2001. The fate of integrated treatment: whatever happened to the biopsychosocial psychiatrist? *American Journal of Psychiatry*, 158(12): 1956-63.

Gabbard, G.O. 2005a. How *not* to teach psychotherapy. *Academic Psychiatry*, 29(4): 332-8.

Gabbard, G.O. 2005b. *Psychodynamic psychiatry*. 4<sup>th</sup> ed. Arlington: American Psychiatric Publishing.

Gabbard, G.O. 2010. *Long-term psychodynamic psychotherapy: A basic text*. 2<sup>nd</sup> ed. Washington, DC: American Psychiatric Publishing.

Gallese, V., Fadiga, L., Fogassi, L. & Rizzolatti, G. 1996. *Action recognition in the premotor cortex*. *Brain*, 119, 593-609.

Gaskin, C.J., Elsom, S.J. & Happel, B. 2007. Interventions for reducing the use of seclusion in psychiatric facilities. *British Journal of Psychiatry*, 191, 298-303. <http://dx.doi.10.1192/bjp.bp.106.034538>

Gelso, C.J., Latts, M.G., Gomez, M.J. & Fassinger, R.E. 2002. Counter-transference management and therapy-outcome: an initial evaluation. *Journal of Clinical Psychology*, 58(7): 861-7. <http://dx.doi.10.1002/jclp.2010>

Gelso, C.J. & Hayes, J.A. 2007. *Countertransference and the therapists' inner experience: perils and possibilities*. Mahwah, NJ: Erlbaum.

Ghaemi, S.N. 2006. Paradigms of psychiatry: Eclecticism and its discontents. *Current Opinion in Psychiatry*, 19, 619–24.

Gilburt, H., Rose, D. & Slade, M. 2008. *The importance of relationships in mental health care: A qualitative study of service users' experience of psychiatric hospital admission in the UK*. *BMC Health Services Research*, 8, 92.

Gillis, L. 2012. The historical development of psychiatry in South Africa since 1652. *South African Journal of Psychiatry*, 18(3): 78-82.

Glaser, B.G. & Strauss, A.L. 1967. *The discovery of grounded theory: strategies for qualitative research*. Chicago: Aldine.

Goffman, E. 1961. *Asylums: essays on the social situation of mental patients and other inmates*. New York: Doubleday Anchor.

Goldberg, A. 2011. The enduring presence of Heinz Kohut: empathy and its vicissitudes. *Journal of the American Psychoanalytic Association*, 59, 289-311. <http://dx.doi.10.1177/0003065111406269>

Goleman, D. 1995. *Emotional intelligence*. New York: Bantam Books.

Gómez, G. & Aillach, E. 2013. Ways to improve the patient-physician relationship. *Current Opinion in Psychiatry*, 26, 453-7.

Gournay, K. 1995. Mental health nurses working purposefully with people with serious and enduring mental illness – an international perspective. *International Journal of Nursing Studies*, 32, 341–52.

Gournay, K., Ward, M., Thornicroft, G. & Wright, S. 1998. Crisis in the capital: inpatient care in inner London. *Mental Health Practice*, 1, 10–8.

Grant, J. & Sandell, R. 2004. Close family or mere neighbours? Some empirical data on the differences between psychoanalysis and psychotherapy. In P. Richardson, C. Renlund & H. Kächele. eds. *Research on psychoanalytic psychotherapy with adults*. London: Karnac: p. 81-107.

Greenberg, J.R. & Mitchell, S.A. 1983. *Object relations in psychoanalytic theory*. Cambridge: Harvard University Press.

Greenson, R.R. 1960. Empathy and its vicissitudes. *International Journal of Psychoanalysis*, 41, 418-24.

Guest, G., Bunce, A. & Johnson, L. 2006. How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, 18(1): 59-82. <http://dx.doi.10.1177/1525822X05279903>

Haglund, K. & Von Essen, I. 2005. Locked entrance doors at psychiatric wards – advantages and disadvantages according to voluntary admitted patients. *Nordic Journal of Psychiatry*, 59, 511-5.

Harlow, H.F. & Harlow, M.K. 1969. Effects of various mother-infant relationships on rhesus monkey behaviors. In Foss, B.M. ed. *Determinants of infant behaviour*. Vol 4. London: Methuen, p. 15-36.

Harrison, P. 2014. Patient expectation largely dictate antidepressant response. [Internet]. Medscape Medical News, Sep15. [cited 2014 Sep 15]. Available from: [http://www.medscape.com/viewarticle/831689?nlid=65743\\_2982&src=wnl\\_edit\\_dail&uac=3110BG#2](http://www.medscape.com/viewarticle/831689?nlid=65743_2982&src=wnl_edit_dail&uac=3110BG#2)

Haw, C., Collyer, J. & Sugarman, P. 2010. Patients' complaints at a large psychiatric hospital: can they lead to better patient services? *International Journal of Health Care Quality Assurance*, 23(4): 400-9. <http://dx.doi.10.1108/09526861011037452>

Heidegger, T., Nuebling, M., Saal, D. & Kreienbühl G. 2008. Patient-centred outcomes in clinical research: does it really matter? *British Journal of Anaesthesia*, 100(1): 1-3.

Heinonen, E., Knekt, P., Jääskeläinen, T. & Lindfors, O. 2014. Therapists' professional and personal characteristics as predictors of outcome in long-term psychodynamic psychotherapy and psychoanalysis. *European Psychiatry*, 29(5): 265-74. <http://dx.doi.org/10.1016/j.eurpsy.2013.07.002>

Henning, E., Van Rensburg, W. & Smit, B. 2004. *Finding your way in qualitative research*. Pretoria: Van Schaik.

Heritage, J., Robinson, J.D., Elliot, M.N., Beckett, M. & Wilkes, M. 2007. Reducing patients' unmet concerns in primary care: the difference one word can make. *Journal of General Internal Medicine*, 22(10): 1429-33.

Hesse, H. 1955. *Steppenwolf*. Frankfurt am Main: Suhrkamp.

Heyes, C. 2010. Where do mirror neurons come from? *Neuroscience & Biobehavioral Reviews*, 34, 575-83. <http://dx.doi.10.1016/j.neubiorev.2009.11.007>

Higgins, R., Hurst, K. & Wistow, G. 1999. Nursing acute psychiatric patients: a quantitative and qualitative study. *Journal of Advanced Nursing*, 29(1): 52–63.

Høglend, P. 2014. Exploration of the patient-therapist relationship in psychotherapy. *American Journal of Psychiatry*, 171(10): 1056-66. <http://dx.doi.10.1176/appi.ajp.2014.140.10121>

Hojat, M., Louis, D.Z., Markham, F.W., Wender, R., Rabinowitz, C. & Gonella, J.S. 2011. Physicians' empathy and clinical outcomes for diabetic patients. *Academic Medicine*, 86, 359-364. <http://dx.doi.10.1097/ACM.0b013e3182086fe1>

Holmes, J. 2010. *Exploring in security. Towards an attachment-informed psychoanalytic psychotherapy*. London: Routledge.

Hooper, L.M., Tomek, S. & Newman, C.R. 2012. Using attachment theory in medical settings: implications for primary care physicians. *Journal of Mental Health*, 21(1): 23-37. <http://dx.doi.10.3109/09638237.2011.613955>

Horne, R. & Clatworthy, J. 2010. Adherence to advice and treatment. In French, D., Vedhara, K., Keptein, A.A. & Weinman, J. eds. *Health psychology*. 2nd ed. Chichester: British Psychological Society, p.175-88.

Howard, P.B., Clark, J.J., Rayens, M.K., Hines-Martin, V., Weaver, P. & Littrell, R. 2001. Consumer satisfaction with services in a regional psychiatric hospital: a collaborative research project in Kentucky. *Archives of Psychiatric Nursing*, 15(1): 10-23.

Howie, J.G., Heaney, D.J. & Maxwell, M. 1997. Measuring quality in general practice. Pilot study of a needs, process and outcome measure. *Occasional Paper of the Royal College of General Practitioners*, 75, i-xii, 1-32.

Hurst, K., Wistow, G & Higgins, R. 1998. Mental health nursing in acute settings. *Mental Health Practice*, 2, 8–11.

Jagosh, J., Boudreau, J.D., Steinert, Y., MacDonald, M.E. & Ingram, L. 2011. The importance of physician listening from the patients' perspective: enhancing diagnosis, healing, and the doctor-patient relationship. *Patient Education and Counseling*, 85(3): 369-74.

Janse van Rensburg, A.B.R., Poggenpoel, M., Myburgh, C.P.H. & Szabo, C.P. 2014a. A model for the role of defined spirituality in South African specialist psychiatric practice and training. *Journal of Religion & Health*, 53, 393–412. <http://dx.doi.10.1007/s10943-012-9644-3>

Janse van Rensburg, A.B.R. 2014b. South African Society of Psychiatrists guidelines for the integration of spirituality in the approach to psychiatric practice. *South African Journal of Psychiatry*, 20(4): 133-9. <http://dx.doi.10.7196/SAJP.593>

Jaspers, K. 1986. *Der Arzt im technischen Zeitalter*. München: Piper.

Jette, D., Grover, L. & Keck, C.P. 2003. A qualitative study of clinical decision making in recommending discharge placement from the acute care setting. *Physical Therapy*, 83(3): 224-36.

Johansson, H. & Eklund, M. 2003. Patients' opinion on what constitutes good psychiatric care. *Scandinavian Journal of the Caring Sciences*, 17, 339-46.

- Josephson, AM. & Peteet, J.R. 2007. Talking with patients about spirituality and worldview: practical interviewing techniques and strategies. *Psychiatric Clinics of North America*, 30(2): 181-97.
- Jungfer, H-A., Schneeberger, A.R., Borgwardt, S., Walter, M., Vogel, M., Gairing, S.K., Lang, U.E. & Huber, C.G. 2014. Reduction of seclusion on a hospital-wide level: successful implementation of a less restrictive policy. *Journal of Psychiatric Research*, 54, 94-9. <http://dx.doi.10/1016/j.psychires.2014.03.020>
- Kandel, E.R. 1998. A new intellectual framework for psychiatry. *American Journal of Psychiatry*, 155, 457-69.
- Kandel, E.R. 1999. Biology and the future of psychoanalysis: a new intellectual framework for psychiatry revisited. *American Journal of Psychiatry*, 156(4): 505-24.
- Kay, J. 2006. The essentials of psychodynamic psychotherapy. *Focus*, 4, 167-72.
- Kelle, U. 1995. Theories as heuristic tools in qualitative research. In Maso, I., Atkinson, P.A., Delamont, S. & Verhoeven JC. eds. *Openness in research. The tension between self and other*. Assen: van Gorcum, p. 33-50.
- Kernberg, O.F. 2014. On overview of the treatment of severe narcissistic pathology. *International Journal of Psychoanalysis*, 95, 865-88. <http://dx.doi.10.1111/1745-8315.12204>
- Kikooma, J.F. 2010. Using qualitative data analysis software in a social constructionist study of entrepreneurship. *Qualitative Research Journal*, 10(1): 40-51.
- Klein, J. 1987. *Our need for others and its roots in infancy*. London: Tavistock.

Klinkenberg, W.D., Boslaugh, S., Waterman, B.M., Otani, K., Inguanzo, J.M., Gnida, J.C. & Dunagan, W.C. 2011. Inpatients' willingness to recommend: a multilevel analysis. *Health Care Management Review*, 36(4): 349-58. <http://dx.doi.10.1097/HMR.0b013e3182104e4a>

Krupnick, J.L., Sotsky, S.M., Simmens, S., Moyer, J., Elkin, I., Watkins, J. & Pilkonis, P.A. 1996. The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: Findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology*, 6, 532-9.

Kvale, S. 1996. *Interviews: An introduction to qualitative research interviewing*. Thousand Oaks, CA: Sage.

La Farge, L. 2000. Interpretation and containment. *International Journal of Psychoanalysis*, 81, 67-84.

Langewitz, K., Denz, M., Keller, A., Kiss, A., Rütteman, S. & Wössmer, B. 2002. Spontaneous talking time at start of consultation in outpatient clinic: cohort study. *British Medical Journal*, 325(7366): 682-3.

Lee, Y-Y. & Lin, J.L. 2011. How much does trust really matter? A study of the longitudinal effects of trust and decision-making preferences on diabetic outcomes. *Patient Education and Counselling*, 85(3): 406-12.

Lemma, A. 2014. The body of the analyst and the analytic setting: Reflections on the embodied setting and the symbiotic transference. *International Journal of Psychoanalysis*, 95, 225-44. <http://dx.doi.10.1111/1745-8315.12147>

Leuchter, A.F., Hunter, A.M., Tartter, M. & Cook, I. A. 2014. Role of pill-taking, expectation and therapeutic alliance in the placebo response in clinical trials for major depression. *British Journal of Psychiatry*, 205(6): 443-9. <http://dx.doi.10.1192/bjp.bp.113.140343>

Levine, H.B. 2007. A note on notes: Note taking and containment. *Psychoanalytic Quarterly*, 76, 981-90.

Levine, S., Haltmeyer, G.C., Kaas, G.G. & Penenberg, V.H. 1967. Physiological and behavioral effects of infantile stimulation. *Physiology & Behavior*, 2, 55-63.

Lincoln, Y. & Guba E. 1999. Establishing trustworthiness. In Bryman A, Burgess RG. eds. *Qualitative Research*. Vol III. London: Sage, p. 397-444.

Little, P., Everitt, H., Williamson, I., Warner, G., Moore, M., Gould, C., Ferrier, K. & Payne S. 2001. Observational study of effect of patient centredness and positive approach on outcomes of general practice consultations. *British Medical Journal*, 323, 908-11. <http://dx.doi.org/10.1136/bmj.323.7318.908>

Liu, D., Diorio, J., Tannenbaum, B., Caldji, C., Francis, D., Freedman, A., Sharma, S., Pearson, D., Plotsky, P.M., Meaney & M.J. 1997. Maternal care, hippocampal glucocorticoid receptors, and hypothalamic-pituitary-adrenal responses to stress. *Science*, 277, 1659-62.

Lloyd-Evans, B., Johnson, S., Morant, N., Gilbert, H., Osborn, D.P.J., Jagielska, D., Skinner, R., Leese, M., Shepherd, G. & Slade, M. 2010. Alternatives to standard acute in-patient care in England: Differences in content of care and staff-patient contact. *British Journal of Psychiatry*, 197, s46-s51. <http://dx.doi.10.1192/bjp.bp.110.081117>

Mahoney, D., Diaz, V., Thiedke, C., Mallin, K., Brock, C., Freedy, J. & Johnson, A. 2013. Balint groups: The nuts and bolts of making better doctors. *International Journal of Psychiatry in Medicine*, 45(4): 401-11.

Malherbe, P. 2014. Recovery in serious mental illness. Post-graduate lecture. Pretoria: University of Pretoria.

Marvel, M.K., Epstein, R.M., Flowers, K. & Beckman, H.B. 1999. Soliciting the patient's agenda: have we improved? *JAMA*, 281, 283-7.

Mason, M. 2010. Sample size and saturation in PhD studies using qualitative interviews. [Internet]. Forum: Qualitative Social Research, 11(3), Art 8. [cited 2013 Jul]. Available from: <http://nbn-resolving.de/urn:nbn:de:0114-fqs100387>

Mathews, F. 2003. *For love of matter: A contemporary panpsychism*. Albany: State University of New York Press.

McIntyre, K., Farrell, M. & David, A.S. 1989. What do psychiatric inpatients really want? *British Medical Journal*, 298, 159-60.

McKay, K.M., Imel, Z.E. & Wampold, B.E. 2006. Psychiatrist effects in the psychopharmacological treatment of depression. *Journal of Affective Disorders*, 92, 287-90.

Meehan, T.J., King, R.J., Beavis, P.H., & Robinson, J.D. 2008. Recovery-based practice: Do we know what we mean or mean what we know? *Australian & New Zealand Journal of Psychiatry*, 42, 177-82.

Menninger, W.C. 1967. *Psychiatrist for a troubled world: Selected papers of William C. Menninger*. New York: Viking Press.

Mental Health America. 2015. Parity or disparity: The state of mental health in America 2015. [Internet]. [cited 2015 Jan 17]. Available from: [http://www.mentalhealthamerica.net/sites/default/files/Parity\\_per\\_cent20or\\_per\\_cent20Disparity\\_per\\_cent202015\\_per\\_cent20Report.pdf](http://www.mentalhealthamerica.net/sites/default/files/Parity_per_cent20or_per_cent20Disparity_per_cent202015_per_cent20Report.pdf)

Mental Health Care Act, No. 17 of 2002. [Internet]. [cited 2014 Aug 18]. Available from: [http://www.justice.gov.za/legislation/acts/2002-017\\_mentalhealthcare.pdf](http://www.justice.gov.za/legislation/acts/2002-017_mentalhealthcare.pdf)

Mercer, S.W. & Reynolds, W.J. 2002. Empathy and quality of care. *British Journal of General Practice*, 52, S9- S13.

Mezzich, J.E. 2005. Positive health: conceptual place, dimensions and implications. *Psychopathology*, 38, 177-9.

Mezzich, J.E. 2010. World Psychiatric Association perspectives on person-centered psychiatry and medicine. *International Journal of Integrated Care*, 10(Suppl), e003.

Mezzich, J.E. 2011. Building person-centered medicine through dialogue and partnerships: perspective from the international network for person-centered medicine. *International Journal of Person Centered Medicine*, 1, 10-3.

Mezzich, J.E., Salloum, I.M., Cloninger, C.R., Salvador-Carulla, L., Kirmayer, L.J., Banzato, C.E.M., Wallcraft, J. & Botbol, M. 2010. Person-centred integrative diagnosis: conceptual bases and structural model. *Canadian Journal of Psychiatry*, 55(11): 701-8.

Mezzich, J.E., Christodoulou, G.N. & Fulford, K.W.M. 2011. Introduction to the conceptual bases of psychiatry for the person. *International Journal of Person Centered Medicine*, 1, 121-4.

Mikesell, L. 2013. Medicinal relationships: caring conversation. *Medical Education*, 47, 443-452. <http://dx.doi.10.1111/medu.12104>

Miklowitz, D.J. 2008. Adjunctive psychotherapy for bipolar disorder: State of the evidence. *American Journal of Psychiatry*, 165, 1408-19.

Miles, M. & Mezzich, J.E. 2011. Advancing the global communication of scholarship and research for personalized healthcare. *International Journal of Person Centered Medicine*, 1(1): 1-5.

Milner, M. 1952. Aspects of symbolism in comprehension of the not-self. *International Journal of Psycho-Analysis*, 33, 181-94.

Mintz, D. 2013. Teaching psychoanalytic concepts, skills, and attitudes to medical students. *Journal of the American Psychoanalytic Association*, 61, 751-70.  
<http://dx.doi.10.1177/0003065113491589>

Mintz, D.L. & Flynn, D.F. 2012. How (not what) to prescribe: nonpharmacologic aspects of psychopharmacology. *Psychiatric Clinics of North America*, 35, 143-63.

Mojtabai, R. & Olfson, M. 2008. National trends in psychotherapy by office-based psychiatrists. *Archives of General Psychiatry*, 65(8): 962-70.

Moore, B. & Fine, B. eds. 1990. *Psychoanalytic terms and concepts*. New York: American Psychoanalytic Association.

Moreau, A., Carol, L., Dedianne, M.C., Dupraz, C., Perdrix, C., Lainé, X. & Souweine G. 2012. What perception do patients have about decision making? Towards an integrative patient-centered care model. A qualitative study using focus-groups interviews. *Patient Education and Counseling*, 87, 206-11.

Morse, J.M. 2008. Styles of collaboration in qualitative inquiry. *Qualitative Health Research*, 18(1): 3-4.

Mouton, J. 2001. *How to succeed in your master's and doctoral studies*. Pretoria: Van Schaik.

Muijen, M. 1999. Acute hospital care: ineffective, inefficient and poorly organized. *Psychiatric Bulletin*, 23, 257-9.

Mullen, A. 2009. Mental health nurses establishing psychosocial interventions within acute inpatient settings. *International Journal of Mental Health Nursing*, 18(2): 83-90. <http://dx.doi.10.1111/j.14470349.2008.00578.x>

Müller, A. & Poggenpoel, M. 1996. Patients' internal world experience of interacting with psychiatric nurses. *Archives of Psychiatric Nursing*, (3): 143-50.

Nature. Editorial. 2012. Therapy deficit: studies to enhance psychological treatments are scandalously under-supported. *Nature*, 489(4717): 473-4. <http://dx.doi.10.1038/489473b>

Ndetej, D.M. & Mbwanyo, A.W. 2010. Another side of African psychiatry in the 21<sup>st</sup> century: chaining as containment. *African Journal of Psychiatry*, 13: 3-5.

Nieuwenhuis, J. 2007a. Introducing qualitative research. In Maree K. ed. *First steps in research*. Pretoria: Van Schaik, p. 46-8.

Nieuwenhuis, J. 2007b. Qualitative research designs and data gathering techniques. In Maree K.ed. *First steps in research*. Pretoria: Van Schaik, p. 69-7.

Nieuwenhuis, J. 2007c. Analysing qualitative data. In Maree K. ed. *First steps in research*. Pretoria: Van Schaik, p. 98-122.

Nijman, H., Allertz, W., Merckelbach, H., à Campo, J. & Ravelli, D. 1997. Aggressive behaviour on an acute psychiatric admission ward. *European Journal of Psychiatry*, 11, 106–14.

Nissen-Lie, H.A., Havik, O.E., Høglend, P.A., Monsen, J.T. & Rønnestad, M.H. 2013. The contribution of the quality of therapists' personal life to the development of the working alliance. *Journal of Counseling Psychology*, 60(4): 483-95. <http://dx.doi.10.1037/a0033643>

Norcross, J.C. & Lambert, M.J. 2011. Evidence-based therapy relationships. In J.C. Norcross. ed. *Psychotherapy relationships that work: Empirically-based responsiveness*. 2<sup>nd</sup> ed. New York, NY: Oxford University Press, p. 3-21.

Norfolk, T., Birdi, K. & Walsh, D. 2007. The role of empathy in establishing rapport in consultation: A new model. *Medical Education*, 41, 690-7.

Nunes, P., Williams, S., Sa, B. & Stevenson, K. 2011. A study of empathy decline in students from five health disciplines during their first year of training. *International Journal of Medical Education*, 2, 12–7.

Nyklicek, I., Vingerhoets, A. & Zeelenberg, M. 2011. *Emotion regulation and well-being*. New York: Springer.

O'Brien, L. & Cole, R. 2004. Mental health nursing practice in acute psychiatric close-observation areas. *International Journal of Mental Health Nursing*, 13, 89–99.

Ogden, T.H. 1986. *The matrix of the mind*. Northvale: Jason Aronson.

Ogden, T.H. 2004. On holding and containing, being and dreaming. *International Journal of Psychoanalysis*, 85, 1349-64.

*Oxford Dictionary of English*. 2005. 2<sup>nd</sup> ed. Oxford: Oxford University Press.

Parker, S. & Leggett, A. 2012. Teaching the clinical encounter in psychiatry: a trial of Balint groups for medical students. *Australasian Psychiatry*, 20(4): 343-7. <http://dx.doi.10.1177/1039856212447965>

Parkin, T., De Looy, A. & Farrand, P. 2014. Greater professional empathy leads to higher agreement about decisions made in the consultation. *Patient Education and Counseling*, 96, 144-50.

- Paul, M. & Bluck, G. 1997. Entering the world of psychotherapy: general psychiatric trainees take their first steps. *British Journal of Psychotherapy*, 14(2): 221-32.
- Pawlikowska, T., Zhang, W., Griffiths, F., Van Dalen, J. & Van der Vleuten, C. 2012. Verbal and non-verbal behavior of doctors and patients in primary care consultations: how this relates to patient enablement. *Patient Education and Counseling*, 86, 70-6.
- Peterson, C. & Seligman, M.E.P. 2004. *Character strengths and virtues: A handbook and classification*. Washington, D.C.: APA Press.
- Plotsky, P.M. & Meaney, M.J. 1993. Early, postnatal experience alters hypothalamic corticotrophin-releasing factor (CRF) mRNA, median eminence CRF content and stress-induced release in adult rats. *Brain Research. Molecular Brain Research*, 18: 195-200.
- Pope, C., Ziebland, S. & Mays, N. 2000. Analysing qualitative data. *British Medical Journal*, 320(7227): 114–6.
- Priebe, S. & Gruyters, T. 1993. The role of the helping alliance in psychiatric community care: a prospective study. *Journal of Nervous and Mental Diseases*, 181(9): 552-7.
- Priebe, S. & Gruyters, T. 1995. Patients' assessment of treatment predicting outcome. *Schizophrenia Bulletin*, 21(1): 87-94.
- Priebe, S., Burns, T. & Craig, T.K.J. 2013. The future of academic psychiatry may be social. *British Journal of Psychiatry*, 202, 319-20.
- Preston, S.D., Hofelich, A.J. & Stansfield, R.B. 2013. The ethology of empathy: a taxonomy of real-world targets of need and their effect on observers. *Frontiers in Human Neuroscience*, 7(488): 1-13. <http://dx.doi.10.3389/fnhum.2013.00488>

- Qureshi, A. & Collazos, F. 2011. The intercultural and interracial therapeutic relationship: challenges and recommendations. *International Review of Psychiatry*, 23(1): 10-9.
- Quirk, A. & Lelliott, P. 2001. What do we know about life on acute psychiatric wards in the UK? A review of the research evidence. *Social Sciences & Medicine*, 53, 1565-74.
- Rapley, T.J. 2001. The art(fullness) of open-ended interviewing: some considerations on analysing interviews. *Qualitative Research*, 1(3): 303-23.
- Reiser, M.F. 1988. Are psychiatric educators "losing the mind"? *American Journal of Psychiatry*, 145(2): 148-53.
- Rhodes, K.V., Vieth, T., He, T., Miller, A., Howes, D.S., Bailey, O., Walter, J., Frankel, R. & Levinson, W. 2004. Resuscitating the physician-patient relationship: emergency department communication in an academic medical center. *Annals of Emergency Medicine*, 44(3): 262-7.
- Richardson, L. 1994. Writing: A method of inquiry. In Denzin, N.K. & Lincoln, Y.S. eds. *Handbook of qualitative research*. Thousand Oaks, CA: Sage. p. 516-29.
- Richardson, L. & St. Pierre, E.A. 2005. Writing: a method of inquiry. In Denzin, N.K. & Lincoln, Y.S. eds. *Handbook of qualitative research*. 3<sup>rd</sup> ed. Thousand Oaks, CA: Sage. p. 959-78.
- Richardson, R. & Kramer, E.H. 2006. Abduction as the type of inference that characterizes the development of a grounded theory. *Qualitative Research*, 6: 497-513.
- Riess, H., Kelly, J.M., Bailey, R.W., Dunn, E.J. & Phillips, M. 2012. Empathy training for resident physicians: a randomized controlled trial of a neuroscience-informed curriculum. *Journal of General Internal Medicine*, 27(10): 1280-6.

Rodenburg, P. 2008. *The second circle: How to use positive energy for success in every situation*. New York: Norton.

Rogers, C.R. 1961. *On becoming a person: A therapist's view of psychotherapy*. Boston, MA: Houghton Mifflin.

Romanyshyn, R.D. 1989. *Technology as dream and symptom*. London: Routledge.

Rønnestad, M.H. & Skovholt, T.M. 2001. Learning arenas for professional development: retrospective accounts of senior psychotherapists. *Professional Psychology: Research and Practice*, 32, 181-7. <http://dx.doi.10.10370735-7028.32.2.181>

Rosenfeld, H. 1987. *Impasse and interpretation: Therapeutic and anti-therapeutic factors in the psychoanalytic treatment of psychotic, borderline, and neurotic patients*. London: Routledge.

Ross, J., Bowers, L. & Stewart, D. 2012. Conflict and containment events in inpatient psychiatric units. *Journal of Clinical Nursing*, 21(15-16): 2306-15. <http://dx.doi.10.1111/j.1365-2702.2012.04073.x>

Røssberg, J.I., Melle, S., Opjordsmoen, S. & Friss S. 2006. Patient satisfaction and treatment environment: A 20-year study from an acute psychiatric ward. *Nordic Journal of Psychiatry*, 60, 176-80.

Sadock, B.J. & Sadock, V.A. eds. 2003. *Kaplan & Sadock's Synopsis of Psychiatry*. 9<sup>th</sup> ed. Philadelphia: Lippincott Williams & Wilkins.

Sadock, B.J. & Sadock V.A, eds. 2005. *Kaplan & Sadock's Comprehensive Textbook of Psychiatry*. 8<sup>th</sup> ed. Philadelphia: Lippincott Williams & Wilkins.

Saks, E.R. 2007. *The center cannot hold*. New York, NY: Hyperion.

- Sandell, R., Blomberg, J., Lazar, A., Carlson, J., Broberg, J. & Schubert, J. 2000. Varieties of long-term outcome among patients in psychoanalysis and long-term psychotherapy: a review of findings in the Stockholm Outcome of Psychoanalysis and Psychotherapy Project (STOPP). *International Journal of Psychoanalysis*, 81, 921-42.
- Schurink, W. 2009. The internal audit as tool to enhance the quality of qualitative research. *Journal of Public Administration*, 44(4.2): 788-802.
- Schurink, W.J., Krüger, C., Bergh, A-M., Van Staden, C.W., Roos, J.L., Pickworth, G.E., Joubert, P.M., Du Preez, R.R., Grey, S.V. & Lindeque, B.G. 2006. Medical students' perception of their development of 'soft skills' Part I: A qualitative research methodology. *SA Family Practice*, 48(8): 14-14d.
- Schurink, W., Fouché, C.B. & De Vos, A.S. 2011. Qualitative data analysis and interpretation. In De Vos AS, Strydom H, Fouché CB, Delport CSL. *Research at grass roots*. 4<sup>th</sup> ed. Pretoria: Van Schaik, p. 397-423.
- Seedat, S., Stein, D.J., Herman, A., Kessler, R., Sonnega, J., Heeringa, S., Williams, S. & Williams, D. 2008. Twelve-month treatment of psychiatric disorders in the South African Stress and Health Study (World Mental Health Survey Initiative). *Social Psychiatry & Psychiatric Epidemiology*, 43(11): 889-97. <http://dx.doi.10.1007/s00127-008-0399-9>
- Shank, G. 1998. The extraordinary powers of abductive reasoning. *Theory and Psychology*, 8(6): 841-60.
- Shapiro, E.R. 2012. Management vs. interpretation: Teaching residents to listen. *Journal of Nervous and Mental Disease*, 200(3): 204-7. <http://dx.doi.10.1097/NMD.0b013e3182487a3e>
- Shattell, M. 2002. "Eventually it'll be over": The dialectic between confinement and freedom in the world of the hospitalized patient. In Thomas, S.P. & Pollio, H.R. eds.

*Listening to patients: A phenomenological approach to nursing research and practice*. New York: Springer, p. 214-36.

Shedler, J. 2010. The efficacy of psychodynamic psychotherapy. *American Psychologist*, 65(2): 98-109. <http://dx.doi.10.1037/a0018378>

Silverstein, S.M. & Bellack, A.S. 2008. A scientific agenda for the concept of recovery as it applies to schizophrenia. *Clinical Psychology Review*, 28, 1108-24.

Sin, J. & Scully, E. 2008. An evaluation of education and implementation of psychosocial interventions within one UK mental healthcare trust. *Journal of Psychiatric and Mental Health Nursing*, 15, 161–9.

Sluzki, C.E. 2007. Interfaces: toward a new generation of systemic models in family research and practice. *Family Process*, 46 (2): 173-84. <http://dx.doi.10.1111/j.1545-5300.2007.00202.x>

Smith, E.M., Msetfi, R.M. & Golding, L. 2010. Client self-rated adult attachment patterns and the therapeutic alliance: a systematic review. *Clinical Psychology Review*, 30(3): 326-37. <http://dx.doi.10.1016/j.cpr.2009.12.007>

Soldani, F., Ghaemi, S.N. & Baldessarini, R.J. 2005. Research reports on treatments for bipolar disorder: preliminary assessment of methodological quality. *Acta Psychiatrica Scandinavica*, 112, 72–4.

SouthAfrica.info. 2012. Gauteng province, South Africa. [Internet]. [cited 2014 Aug 18]. Available from: <http://www.southafrica.info/about/geography/gauteng.htm>.

SouthAfrica.info. 2013. South Africa's newspapers. [Internet]. [cited 2014 Sep 15]. Available from: <http://www.southafrica.info/about/media/newspapers.htm#.VBcG9GSSxZF>

Stake, R.E. 2005. Qualitative case studies. In Denzin, N.K. & Lincoln. eds. *The Sage handbook of qualitative research*. Thousand Oaks, CA: Sage.

Stein, M.T. 2010. Developing a therapeutic relationship: can it be taught? *Journal of Developmental Behavioral Pediatrics*, 31(6): 511-2.

Steinert, T., Lepping, P., Bernhardsgrutter, R., Conca, A., Hatling, T., Janssen, W., Keski-Valkama, A., Mayoral, F. & Whittington, R. 2010. Incidence of seclusion and restraint in psychiatric hospitals: A literature review and survey of international trends. *Social Psychiatry & Psychiatric Epidemiology*, 45(9): 889-97. <http://dx.doi.10.1007/s00127-009-0132-3>

Stephenson, J.J., Tunceli, O., Gu, T., Eisenberg, D., Panish, J., Crivera, C. & Dirani R. 2012. Adherence to oral second-generation antipsychotic medications in patients with schizophrenia or bipolar disorder: physicians' perceptions of adherence vs. pharmacy claims. *International Journal of Clinical Practice*, 66, 565-73.

Stewart, M., Brown, J.B., Donner, A., McWhinney, I.R., Oates, J., Weston, W.W. & Jordan, J. 2000. The impact of patient-centered care on outcomes. *Journal of Family Practice*, 49(9): 796–804.

Stratford, A., Brophy, L. & Castle, D. 2012. Integrating recovery-oriented practice into psychiatric registrar training. *Australasian Psychiatry*, 20(6): 524-6. <http://dx.doi.10.1177/1039856212465349>

Strauss, A. & Corbin, J. 1990. *Basics of qualitative research*. Los Angeles: Sage.

Strydom, H. & Delpont, C.S.L. 2011. Sampling and pilot study in qualitative research. In: De Vos, A.S., Strydom, H., Fouché, C.B. & Delpont, C.S.L. *Research at grass roots*. 4<sup>th</sup> ed. Pretoria: Van Schaik, p. 309.

Stubbe, D.E. 2014. Time in a bottle: the psychopharmacologist – patient relationship in “split-treatment” models of care. *Focus*, 12(2): 169-71.

Suibhne, S. M. 2011. Erving Goffman's asylums 50 years on. *British Journal of Psychiatry*, 198, 1–2. <http://dx.doi.10.1192/bjp.bp.109.077172>

Svensson, I., Sjostrom, B. & Haljamae H. 2001. Influence of expectations and actual pain experiences on satisfaction with postoperative pain management. *European Journal of Pain*, 5, 125-33.

Swartz, L. 1998. *Culture and mental health: A Southern African view*. Cape Town: Oxford University Press.

Sweet, V. 2012. *God's Hotel*. New York, NY: Riverhead Books.

Sylvia, L.G., Hay, A., Ostacher, M.J., Miklowitz, D.J., Nierenberg, A.A., Thase, M.E., Sachs, G.S., Deckersbach, T. & Perlis, R.H. 2013. Association between therapeutic alliance, care satisfaction, and pharmacological adherence in bipolar disorder. *Journal of Clinical Psychopharmacology*, 33, 343-50. <http://dx.doi.10.1097/JCP.0b013e3182900c6f>

Symington, J. & Symington, N. 1996. *The clinical thinking of Wilfred Bion*. London: Routledge.

Symington, N. 2007. *Becoming a person through psychoanalysis*. London: Karnac.

Symington, N. 1996. *The making of a psychotherapist*. London: Karnac.

*The Concise Oxford Dictionary*, 7<sup>th</sup> ed. 1982. Oxford: Oxford University Press.

Thomas, S.P., Shattell, M. & Martin, T. 2002. What's therapeutic about the therapeutic milieu? *Archives of Psychiatric Nursing*, Vol. XVI (3): 99-107. <http://dx.doi.10.1053/apnu.2002.32945>

Treloar, A. J. C. 2009. Effectiveness of education programs in changing clinicians' attitudes toward treating borderline personality disorder. *Psychiatric Services*, 60(8): 1128-31. <http://dx.doi.10.1176/appi.ps.60.8.1128>

Trivedi, M.H., Rush, A.J., Wisniewski, S.R., Nierenberg, A.A., Warden, D., Ritz, L., Norquist, G., Howland, R.H., Lebowitz, B., McGrath, P.J, Shores-Wilson, K., Biggs, M.M., Balusabramani, G.K. & Fava, M. 2006. Evaluation of outcomes with citalopram for depression using measurement-based care in STAR\*D: implications for clinical practice. *American Journal of Psychiatry*, 163, 28-40.

Unluer, S. 2012. Being an insider researcher while conducting case study research. [Internet]. [cited 2013 Jul 16]. *The Qualitative Report*, 17(Art 58): 1-14. Available from: <http://www.nova.edu/ssss/QR/QR17/unluer.pdf>

*Urban Dictionary*. 2015. [Internet]. [cited 2015 Feb 6]. Available from: [www.urbandictionary.com/define.php?term=eish](http://www.urbandictionary.com/define.php?term=eish)

Vaillant, G.E. 2003. Mental health. *American Journal of Psychiatry*, 160(8): 1373-84.

Van den Berg, J.H. 1972. *A different existence*. Pittsburgh: Duquesne University Press.

Van den Berg, J.H. 1978. *Medical power and medical ethics*. New York: Norton.

Van den Brink-Muinen, A., van Dulmen, S., de Haes, H., Visser, A., Schellevis, F. & Bensing J. 2006. Has patients' involvement in the decision-making process changed over time? *Health Expectations*, 9, 333-42.

- Van Staden, C.W. & Krüger, C. 2003. Incapacity to give informed consent owing to mental disorder. *Journal of Medical Ethics*, 29(1): 41-43.
- Van Wynsberghe, R. & Khan, S. 2007. Redefining case study. *International Journal of Qualitative Methods*, 6(2): 80-94.
- Verhaeghe, P. 2004. *On being normal and other disorders: A manual for clinical diagnostics*. New York: Other Press.
- Verlinde, E., De Laender, N., De Maesschalck, S., Deveugele, M. & Willems, S. 2012. The social gradient in doctor-patient communication. *International Journal of Equity in Health*, 11, 12. <http://dx.doi.10.1186/1475-9276-11-12>
- Vieten, C., Scammell, S., Pilato, R., Ammondson, I., Pargament, K. I., & Lukoff, S. 2013. Spiritual and religious competencies for psychologists. *Psychology of Religion & Spirituality*, 5, 129-44. <http://dx.doi.org/10.1037/a0032699>
- Waddell, M. 1998. *Inside lives*. Trowbridge: Redwood.
- Waitzkin, H. 1985. Information giving in medical care. *Journal of Health and Social Behavior*, 26, 81-101.
- Wallace, E.R. 1983. *Dynamic psychiatry in theory and practice*. Philadelphia: Lea & Febiger,
- Wegner, P. 2014. Process-orientated psychoanalytic work in initial interviews and the importance of the opening scene. *International Journal of Psychoanalysis*, 95, 505-23. <http://dx.doi.10.1111/1745-8315.12143>
- Weissman, M.M. 2013. Psychotherapy: a paradox. *American Journal of Psychiatry*, 170(7): 712-5.

Wilson, E.O. 2014. *The meaning of human existence*. New York: Liveright.

Winek, J.L. 2010. *Systemic family therapy*. Los Angeles: Sage.

Winerman, L. 2005. The minds mirror. *Monitor on Psychology*, 36(9): 48.

Winnicott, D.W. 1960. The theory of the parent-infant relationship. In David E. Scharff (ed). *Object relations theory and practice*. Northvale, New Jersey: Jason Aronson. p. 225-35.

Winnicott, D.W. 1971. *Playing and reality*. London: Routledge.

Winston, A., Rosenthal, R.N. & Pinsker, H. 2004. *Introduction to supportive psychotherapy*. Washington DC: American Psychiatric Publishing.

Winston, A., Rosenthal, R.N. & Pinsker, H. 2012. *Learning supportive psychotherapy*. Washington DC: American Psychiatric Publishing.

Wolcott, H.F. 2002. Writing up qualitative research ... better. *Qualitative Health Research*, 12(1): 91-103. <http://dx.doi.10.1177/1049732302012001007>

World Health Organization. 2012. Depression- fact sheet. [Internet]. Geneva: World Health Organization. [cited 2013 Jun 15]. Available from: <http://www.who.int/mediacentre/factsheets/fs369/en/>

Xu, M.A. & Storr, G.B. 2012. Learning the concept of researcher as instrument in qualitative research. [Internet]. [cited 2013 Jun 21]. *The Qualitative Report*, 17(Art 42), 1-18. Available from: <http://www.nova.edu/ssss/QR/QR17/storr.pdf>

Zachariae, R., Pederson, C.G., Jensen, A.B., Ehrnrooth, E., Rossen, P.B., & Von der Maase, H. 2003. Association of perceived physician consultation style with patient

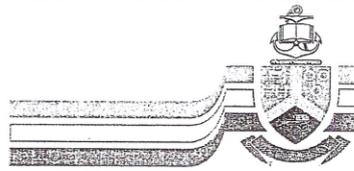
satisfaction, distress, cancer-related self-efficacy, and perceived control over the disease.  
*British Journal of Cancer*, 88, 659-65.

## APPENDICES

- a. Letters of approval
- b. Patient information leaflet and consent form
- c. Patient questionnaire

## APPENDIX A: LETTERS OF APPROVAL

Kamer 4-44  
HW Snyman Noord  
Tel: (012) 354-1201  
Faks: (012) 354-1241  
E-pos: emmie@up.ac.za



Universiteit van Pretoria

Posbus 667, Pretoria, 0001, Republiek van Suid-Afrika  
<http://www.up.ac.za>  
Tel: (012) 354-1000  
Faks: (012) 354-1111

Kantoor van die Voorsitter  
Skool vir Geneeskunde  
Fakulteit Gesondheidswetenskappe

16 August 2013

Prof C Kruger  
Department Psychiatry  
Weskoppies Hospital  
UNIVERSITEIT VAN PRETORIA

Prof

**STUDENT: BOHMER MW (PhD PSYCHIATRY)**

**"The therapeutic relationship as reflected in the experiences of hospitalized psychiatric patients: An explorative-descriptive study"**

During the meeting held on the 13<sup>th</sup> of August 2013 abovementioned protocol was approved.

Kind regards

**PROF BG LINDEQUE**  
**VOORSITTER: PhD KOMITEE**

c.c. Me A Vijoen

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved dd 22 May 2002 and Expires 20 Oct 2016.
- IRB 0000 2235 IORG0001762 Approved dd 13/04/2011 and Expires 13/04/2014.



UNIVERSITEIT VAN PRETORIA  
UNIVERSITY OF PRETORIA  
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

19/09/2013

Approval Certificate  
New Application

Ethics Reference No.: 354/2013

**Title:** The therapeutic relationship as reflected in the experiences of hospitalised psychiatric patients: An explorative-descriptive study. **Dept:** Psychiatry, Weskoppies Hospital, University of Pretoria.  
**Cell:** 083 940 7159 **E-Mail:** [Manfred.Bohmer@up.ac.za](mailto:Manfred.Bohmer@up.ac.za) **Tel:** 012 319 9722

Dear Dr Manfred W Böhmer

The **New Application** as supported by documents specified in your cover letter for your research received on the 28 August 2013, was approved by the Faculty of Health Sciences Research Ethics Committee on the 18/09/2013 .

Please note the following about your ethics approval:

- Ethics Approval is valid for March 2016 Total Duration: 3 years.
- Please remember to use your protocol number (**354/2013**) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

**Ethics approval is subject to the following:**

- The ethics approval is conditional on the receipt of 6 monthly written Progress Reports, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

**Dr R Sommers; MBChB; MMed (Int); MPharMed.**

**Deputy Chairperson** of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

*The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).*

◆ Tel: 012-3541330

◆ Web: [//www.healthethics-up.co.za](http://www.healthethics-up.co.za)

◆ Fax: 012-3541367 Fax2Email: 0866515924

◆ H W Snyman Bld (South) Level 2-34

◆ E-Mail: [manda@med.up.ac.za](mailto:manda@med.up.ac.za)

◆ Private Bag x 323, Arcadia, Pta, S.A., 0007

## APPENDIX B: PATIENT INFORMATION LEAFLET AND CONSENT FORM

### PARTICIPANTS' INFORMATION LEAFLET AND INFORMED CONSENT FORM TITLE OF STUDY:

**The therapeutic relationship as reflected in the experiences of hospitalised psychiatric patients: An explorative-descriptive study**

Dear Mr. / Mrs. / Ms. ....

Date: .....

#### 1. Introduction

You are invited to volunteer for a research study. This information leaflet is to help you decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions, which are not fully explained in this leaflet do not hesitate to ask the investigator. You should not agree to take part unless you are completely happy about all the procedures involved. In the best interest of your health, it is strongly recommended that you discuss with or inform your personal doctor of your possible participation in this study, wherever possible.

#### 2. The nature and purpose of the study

The aim of this study is to understand patients' experiences in Weskoppies Hospital, to understand what is important to them and what role the interaction with the different members of the multi-professional team plays during hospitalisation. By doing so we wish to learn more about what patients regard as helpful and how they interact with members of the treating team.

#### 3. Explanation of procedures to be followed

If you participate the researcher will hold two or possibly three interviews with you about your stay in Weskoppies Hospital. Each interview will be conducted in the ward and will last about 45 – 50 minutes.

#### 4. Risk and discomfort involved

There is no risk associated with participating in this study, although some people may find it uncomfortable to reflect on certain experiences. You do not have to answer questions that are for you of a sensitive nature.

#### 5. Possible benefits of this study

This study could help to better understand how patients perceive treatment and could contribute to better training of registrars and to develop a better service for patients.

**6. I understand that if I do not want to participate in this study, I will still receive standard treatment for my illness.**

**7. I may at any time withdraw from this study.**

**8. Ethical approval**

The protocol for the study was submitted to the Faculty of Health Sciences Research Ethics Committee and that committee has granted written approval. The study has been structured in accordance with the Declaration of Helsinki (last update: October 2008), which deals with the recommendations guiding doctors in biomedical research involving patients. A copy of the Declaration may be obtained from the investigator should you wish to review it.

**9. Information**

If you have any questions concerning this study you can contact Dr MW Böhmer at tel. 012 319 9500 or 012 319 9741.

**10. Confidentiality**

All records obtained whilst in this study will be regarded as confidential. Results will be published or presented in such a fashion that patients remain unidentifiable.

**11. Consent to participate in this study**

I have read or had read to me in a language that I understand the above information before signing this consent form. The content and meaning of this information have been explained to me. I have been given the opportunity to ask questions and am satisfied that they have been answered satisfactorily. I understand that if I do not participate it will not alter my management in any way. I hereby volunteer to take part in this study.

I have received a signed copy of this informed consent agreement.

.....	.....
Patient	Date
.....	.....
Person obtaining informed consent	Date
.....	.....
Witness	Date

**Verbal patient informed consent (if applicable)**

I the undersigned, Dr ..... have read and have explained fully to the patient, named ..... and/or his/her relative, the information leaflet, which has indicated the nature and purpose of the study in which I have asked the patient to participate. The explanation I have given has mentioned both the possible risks and benefits of the study and the alternative treatments available for his/her illness. The patient indicated that he/she understands that he/she will be free to withdraw from the study at any time for any reason and without jeopardizing his/her treatment.

I hereby certify that the patient has agreed to participate in this study.

Patient's name: ..... (please print)

Investigator's name: ..... (please print)

Investigator's signature: .....

Witness's name: ..... (please print)

Witness's signature: ..... Date: .....

## **APPENDIX C: PATIENT QUESTIONNAIRE**

### **The questionnaire or interview guide in the planning phase (July 2013)**

1. How did you experience your time in Weskoppies Hospital?
2. Was there anything that stood out?
3. Was anything missing in terms of your stay and treatment?
4. Was anything during admission helpful?
5. What do you consider to be good psychiatric care?
6. Did anyone become important to you?
7. Why this person?
8. What are his or her qualities?
9. With whom would you like to follow up?
10. Why with this person?
11. How did you feel about the registrar?
12. How do you see the role of the registrar?
13. What was your most helpful experience with the registrar?
14. What was the least helpful experience with the registrar?

### **The questionnaire in September 2013 (before the data gathering started)**

#### **1. Experiences in the hospital**

- a. How long have you been in the hospital?
- b. How do you or how did you experience your time in Weskoppies Hospital?  
Please tell me more about your experience of being in this hospital.
- c. Was there anything that stood out?
- d. Was anything missing in terms of your stay and treatment?
- e. Was anything during admission meaningful and helpful?
- f. What do you consider to be good psychiatric care?

#### **2. Relations**

- a. Did anyone become important to you?
- b. Why this person?

- c. What are his or her qualities?
- d. With whom would you like to follow up?
- e. Why with this person?

### **3. The registrar**

- a. How do you feel about the registrar?
- b. How do you see the role of the registrar?
- c. What was your most helpful experience with the registrar?
- d. What was the least helpful experience with the registrar?
- e. How soon after admission did the registrar of your team see you?
- f. How often did the registrar consult with you?
- g. How long was each consultation with the registrar?
- h. What is the name of your registrar?

### **4. Training**

- a. What do you think of the training of the team at the hospital?
- b. Do you think they had the necessary training to help you? That their training was good enough?
- c. What is your opinion about the type and quality of the training of the registrars?

## **The final questionnaire**

### **1. Experiences in the hospital**

- a. How long have you been in the hospital?
- b. How do you or how did you experience your time in Weskoppies Hospital? Please tell me more about your experience of being in this hospital. How is it to be here? What happens here?
- c. Was there anything that stood out? What was your most important experience or experiences?
- d. Was anything during admission meaningful and helpful?
- e. Was anything missing or lacking in terms of your stay and treatment?
- f. What do you know about the team or firm in which you have been admitted? Who are the members? By whom have you been seen?

- g. Was your stay lonely? If yes, why? If not, why not?

## 2. The registrar

- a. What is the name of your registrar?
- b. How soon after admission did the registrar of your team see you?
- c. How often did the registrar consult with you?
- d. How long was each consultation with the registrar?
- e. How do you feel about the registrar?
- f. How do you see the role of the registrar?
- g. What was your most helpful experience with the registrar?
- h. What was the least helpful experience with the registrar?
- i. Was there anything lacking, missing in the interaction with the registrar?

## 3. Relations

- a. Did anyone become important to you? Or even became a role model?
- b. Why this person?
- c. What are his or her qualities?
- d. Did a therapeutic relationship develop? By this I mean whether a professional interaction developed between you and a member of the multi-professional team (MDT) that became meaningful and helpful to you?
- e. Or was the interaction with another patient rather more meaningful?
- f. How important do you think is such a therapeutic relationship or interaction in the process of healing, of getting better? Of having one person to whom you can talk over a longer period of time? Who in a way accompanies you in your struggle with your problems?
- g. How did this therapeutic relationship or interaction affect the outcome of your treatment? How did the absence of such a therapeutic relationship affect the outcome of your treatment?
- h. How would you describe a therapeutic relationship? What is it? How would you define it? What are the components of it? Does it differ from friendship?

## 4. Environment

- a. How did the environment affect all of this?

- b. Being in a closed or open ward?
5. How was the care in this hospital? Are you satisfied with the treatment and care you received? What helped you to get better? What do you think is good psychiatric care?
- 6. Training**
- a. What do you think of the training of the team at the hospital?
  - b. Do you think they had the necessary training to help you? That their training was good enough?
  - c. What is your opinion about the type and quality of the training of the registrars?
7. With whom would you like to follow up? Why with this person?
8. Is there anything else that you want to mention about your stay here?