

**AN EVALUATION OF THE FILM *ONE FLEW OVER THE CUCKOO'S NEST* AS A MEDIUM FOR THE TRAINING OF PSYCHOTHERAPISTS**

Submitted by

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## ABSTRACT

The aim of the study is to analyse the film *One flew over the cuckoo's nest*, from a clinical psychology perspective in order to evaluate the possible use of the film and significant concepts depicted therein in a training context. The objectives of the study are to describe the interactional dynamics of the psychiatric system as depicted in the film, to identify and describe the impact of the systems and/or subsystems on the psychotherapeutic growth of “patients” and to provide suggestions for the training of psychotherapists on the basis of the film and the present research.

A qualitative, descriptive research design was used to achieve these aims. This allowed for systematic clinical descriptions by four clinical psychologists to be obtained. The study involved an exploration of relevant literature as well as an in-depth study of a specific therapeutic group in interaction as depicted in the film.

The film was shown to four clinical psychologists. Their findings were analysed, and common themes in their analyses identified. The researcher came to certain conclusions on the basis of the above-mentioned analyses.

The findings of this study seem to indicate that the interactional style of the psychiatric staff, as portrayed in the film, contributed to the deterioration of the psychological well-being of the “patients”, thus inhibiting their psychological growth and promoting psychopathology. In spite of the findings, the researcher wishes to recommend the utilisation of this film as a training medium, on condition that a paradigm shift is made away from the traditional medical/psychiatric approach to a

systems-based epistemology. This could result in viewing the psychiatric system as a hierarchy of interrelated subsystems-in-interaction, and open up possibilities for a re-definition of the various roles of those involved within the larger system. Further research in this direction is strongly indicated and recommended.

## DECLARATION

I declare that the dissertation hereby submitted to the University of Limpopo, for the degree of Masters in Science in Clinical Psychology has not previously been submitted by me for a degree at this or any other university, that it is my work in design and in execution and that all material contained herin has been duly acknowledged.

February 2010

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L. H. Miller (Mrs)

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## **CHAPTER 1**

### **INTRODUCTION**

Although the origin of psychology can be traced back to early Greek thought, it did not become a separate field until the 1870s. The foundation of clinical and health psychology is part of the tradition of modern and experimental psychology.

Psychology is the study of the psyche and behaviour and their interrelationship. It also seeks to comprehend how humans think, learn, perceive, feel, act and interact with others, as well as understand themselves (Sternberg, 2001).

Clinical psychology is the scientific study and application of psychology in order to understand, prevent and relieve psychologically based distress or dysfunction and promote subjective well-being and personal development.

Clinical psychology may be confused with psychiatry, which usually has related goals (e.g. the alleviation of mental distress). The difference is in the focus of the profession, in which psychiatrists are physicians with medical degrees. As such, psychiatrists tend to focus on medication-based solutions. In practice, clinical psychologists often work in multidisciplinary teams with other professionals, such as psychiatrists, occupational therapists and social workers. This multiprofessional approach often occurs in a psychiatric institution (Wikipedia, 2008). The psychiatric hospital or institution came to be described as a “system”. In describing a psychiatric institution one can deduce that there are systems within the hospital system, such as

patient care, information and finances. These systems are all interrelated in a hierarchy of systems (Carter, 2003).

A conceptual framework that incorporates the idea of “systems” is *general systems theory*. The theory can be used to describe the psychiatric institution from an interpersonal view, because it incorporates the idea of the psychiatric institution as a social system with subsystems (Carter, 2003). The attention shifts from the inside of the individual (intrapsychic) to what happens between individuals (interpsychic). The emphasis is thus on the observable patterns of interaction between individuals (Vorster, 2003). These observable patterns of behaviour are understood in the specific context in which they occur.

Clinical psychology training at the Medical University of South Africa is set in the theoretical paradigm of *general systems theory*, which also forms the theoretical foundation of this study.

The aim of the study is to systematically research the film *One flew over the cuckoo's nest*, and analyse it from a clinical psychology perspective in order to evaluate the use of the film and significant concepts in a training context. An attempt will thus be made to validate the film under investigation as a training instrument in systems theory in a mental hospital, to assist students with their preparation for the internship year following their academic training, which usually occurs in a psychiatric hospital. Training for psychotherapists in a psychiatric hospital is a specific system with

psychiatric concepts. The question arises whether a system in a psychiatric context is sufficient for the training environment of psychotherapists.

This research will focus on the evaluation of the dynamics of the psychiatric system as depicted in the film *One flew over the cuckoo's nest*, as a medium for the training of psychotherapists. The use of *general systems theory* enables the researcher to focus on the context and patterns of interaction between participants in a psychiatric institution. It is important to note how these patterns are established and how the regulation of the psychiatric institution and its subsystems takes place in order to understand the behaviour of its participants (Carter, 2003).

The psychiatric system portrayed in *One flew over the cuckoo's nest* could possibly be used to prepare intern clinical psychologists for their internship year at a psychiatric institution. It could help these students to become aware of possible pitfalls in the system, and how to deal with frustrations in the psychiatric setup. This could optimise the training of intern students. The film thus has the potential to be used as a meaningful medium for training, and this study will attempt to evaluate this possibility.

In chapter 2, the appropriate literature is discussed to establish the theoretical foundations of the study. An outline of the training of psychotherapists at Medunsa will be discussed. Secondly, *general systems theory* will be briefly outlined and the concepts related to its application will be explored. Mental illness and psychotherapeutic growth will subsequently be addressed, followed by an overview

of the film, *One flew over the cuckoo's nest*. Chapter 3 provides an operational link by outlining the appropriate research methodology. Chapter 4 presents and discusses the research findings, while Chapter 5 draws conclusions and make recommendations.

## CHAPTER 2

### LITERATURE SURVEY

#### 2.1 INTRODUCTION

This chapter presents the relevant literature pertaining to the psychiatric system, as depicted in the film, *One flew over the cuckoo's nest*. At the outset, the training at Medunsa will be outlined. Secondly, the literature relevant to general systems theory and the concepts related to its application in this study will be explored. Thereafter, the literature relevant to social systems, the psychiatric institution as a system and psychiatric patient management will be discussed. Thirdly, the focus will be on describing mental illness in order to define the psychotherapeutic growth of the residents in a psychiatric institution. Finally, an overview of *One flew over the cuckoo's nest* will be provided.

#### 2.2 TRAINING OF PSYCHOTHERAPISTS

This research is primarily concerned with training in psychotherapy, with special reference to the clinical psychology training programme at Medunsa.

Training in any field involves a systematic series of activities to which trainees are subjected in order to gain new knowledge, skills or to change behaviour (Plug, Louw, Gouws & Meyer, 1997). According to the *Oxford English Dictionary*, training can be defined as the “systematic instruction in exercise in some art, profession or

occupation, with a view to proficiency in it” (The Concise Oxford Dictionary of Current English, 1995, p. 1479).

### **2.2.1 Definition of training contexts**

Plug et al. (1997) define a psychologist as a person with a postgraduate qualification in psychology, working in one of the streams of psychology such as an educational or clinical field. According to Goldman (2000), psychologists are mental health professionals with doctorates or master’s degrees, who are registered at the Health Professions Council of South Africa as independent practitioners in psychotherapy and psychological assessment. Psychologists first attend university, and then have to complete an internship involving training in psychotherapy, diagnosis and psychological assessment under supervision.

Kottler and Swartz (2004) suggest that the training, particularly in the first year, is a rite of passage that could be regarded as an initiation process. With regard to the training of psychologists, this change involves the movement from lay to professional status. Three phases are involved in the transitional process.

The first phase involves separation from other groups of postgraduate students, and also in various ways from friends and family, owing to the involvement in the course material. The second phase is marked by a fluid and confusing state between student and professional individual. The third phase involves a re-integration into society as a fully qualified professional.

Kottler and Swartz (2004) contend that becoming a clinical psychologist can be a demanding process. The process requires trainees to become intimately involved in the pain, conflicts, disappointments and hardships of the lives of people whose mental health is in some way troubled. The process further requires trainees to examine their own lives and negotiate their way towards a professional identity, whilst being able to deal with the pain of others in a mindful way, as well as protecting themselves in the process.

According to Nel (1992), various orders of learning are required in the different contexts in which psychotherapeutic skills are imparted. Three such contexts, namely education, training and supervision, may be distinguished. Training can be described as a learning context in which trainee therapists learn and develop skills. These skills can be applied to their therapeutic work.

### **2.2.2 Requirements of psychotherapy training programmes**

Clinical training has three major components. The first component, which is introduced in the first year, comprises of lectures and seminars. This constitutes intensive preparation for clinical work, which is complemented by supervision with a limited number of clients (Kottler & Swartz, 2004).

The second component is introduced in the second year and consists of an internship year in a mental hospital setting. Trainees carry a larger caseload and are exposed to a range of mental health settings, such as neurology and therapeutic “in-patient”

programmes. The third component of the course is a research dissertation (Kottler & Swartz, 2004).

Prof. Charl Vorster is the course coordinator of the Clinical Psychology Training programme at Medunsa. Prof. Vorster describes the aims of the psychotherapy training programme as follows: It is to facilitate the trainees within the period of one year to achieve the minimum standards of therapeutic expertise. The trainees should be able to proceed with basic psychotherapy after the year's training, preferably with ongoing supervision for a further two to three years (Bosman, 2004).

According to Tomm and Wright (1979), trainers in psychotherapy should create a context in which training activities facilitate the learning and development of three interrelated sets of skills required by a therapist, namely perceptual, conceptual and executive skills. Perceptual skills refer to the therapist's ability to make relevant and accurate observations. Conceptual skills involve the process of attributing useful meanings to observations, whilst executive skills refer to the successful application of previous learning experiences to a current therapeutic situation. Competence in psychotherapy also requires a solid basis in background knowledge, generic clinical skills, orientation-specific skills and an awareness of professional behaviour and interpersonal sensitivity (Freedheim & Overholser, 1998).

The delicate and complex facets of a therapeutic relationship need a highly skilled and sensitive therapist, who is in control of the psychotherapeutic process. The therapist should also have the necessary knowledge to evaluate and plan his or her

strategies and the skills to implement them (Swart & Wiehahn, 1997). Effective training is therefore essential. In order to achieve these objectives, Swart & Wiehahn (1979, p.78) suggests a comprehensive training programme which includes the following:

- the therapist becoming aware of how he or she is experienced by others and influences them
- “learning by experience” being the key word
- personal involvement of the therapist
- lectures including theoretical background
- discussion groups on theory
- demonstrations
- individual study
- observation
- psychotherapy skills analysis
- tape analysis
- role play
- case study
- practicing skills and techniques with group feedback
- role change
- video recordings

### **2.2.3 The systemic approach in psychotherapy training**

#### ***2.2.3.1 Epistemological change***

There are a variety of approaches to treating individuals and families, as well as a number of ways of passing on the necessary skills to do so. The use of general systems theory (Von Bertalanffy, 1968; Nichols & Everett, 1986) in the social sciences in general, and to psychotherapy in particular, made it necessary to arrange an accommodating transfer in approaches to training psychotherapists (Bosman, 2004). No model of clinical intervention exists in a theoretical vacuum. Every clinical model that is teachable must have an epistemological foundation. According to Nichols and Everett (1986), epistemology is that branch of philosophy that concerns itself with the origins, nature, methods and limits of knowledge. Moore (in Meyer, Moore & Viljoen, 2003, p. 497) defines epistemology “as a particular way of thinking, which determines how we understand the world around us.”

The psychiatric terminology and the classical medical model of psychopathology are an example of traditional linear epistemology. This includes reductionism or atomism, linear causality and neutral objectivity. Reductionism implies that objects can be reduced to their basic elements as a means of understanding the whole object. Linear causality states that the elements are bound to one another by cause and effect. Neutral objectivity states that the truth can only be discovered if the objects are observed objectively and not influenced by the observer (Moore, in Meyer *et.al.*, 2003).

Nonlinear epistemology emphasises ecology, relationships and whole systems. It is attuned to interrelation, complexity and context. General systems theory is concerned with moving away from a reductionist towards a holistic view (Moore, in Meyer *et.al.*, 2003).

Systemic training is thus a movement away from the traditional, linear and fragmented approach towards an emphasis on whole entities or systems (Cunningham, 1999). The key to systemic training is not so much *what* is taught, but *how* it is taught. The emphasis is thus on the process of learning and not only on the content of what is learnt. Broadly viewed, systems training is a process that provides arrangements and resources for the learner, whereby he or she:

- embraces a systemic world view
- understands the concepts that characterise the systems and principles and laws that govern systems behaviour
- learns to use systems methods, models and tools by which to apply systems concepts, principles and laws to conceptual and practical phenomena, and integrates all of these within the general framework of a systems view (Bor, 1984. p. 44).

An example of a clinical psychology training programme, embedded in a systemic epistemology, is the M.Sc. (Clinical Psychology) offered at Medunsa. The training programme acknowledges the influence of the traditional linear approach, whilst

integrating the various approaches in psychology in an appropriate fashion (Bosman, 2004).

#### **2.2.3.2 Training at Medunsa**

Training in clinical psychology at Medunsa, utilises the general systems theory as a meta-theory into which other major theoretical approaches fit logically and constructively (Vorster, 2003). General systems theory as a meta-theory follows certain systemic principles, which allow for the integration of the various theories.

The principles are as follows:

- (1) *Recursively connected hierarchies*. All systems are structured in hierarchically, which allows for the conceptualisation of systems within systems. The recursive patterns of interaction link the systems to their comprising subsystems, allowing them to function independently. As such, the individual, family, enlarged family, and all suburbs, cities and continents are interlinked and receive and give inputs and outputs respectively (Vorster, 2003).
- (2) *Punctuation*. To allow for the observation of various systems or sequences of interaction within these recursive patterns, arbitrary punctuations can be made. Punctuations indicate a particular angle or view which is adopted by an individual and from which position a message is interpreted (Vorster, 2003).
- (3) *Rejection of either/or dualities*. It is possible to punctuate linear sequences within the larger circular patterns, because systemic thought rejects either/or dualities (Vorster, 2003).

According to Vorster (2003), systems theory as a meta-theory provides for the logical flow from one theoretical framework to another. This then allow for interventions from different approaches, depending on the nature of the presenting problem. For instance, whether it involves an intrapsychic conflict, a phobia or a marital problem, adhering to the appropriate punctuation in the systemic structure, allows for intervention techniques from either the psychodynamic, the behavioural or the communications model (Bosman, 2004).

The role of the therapist as a “participant observer” is emphasised during training at Medunsa. The therapist joins the system during the process of psychotherapy and becomes a temporary member of the system. The joining happens irrespective of whether a client is being assisted individually or whether the whole family is present in the consulting room. The therapist is not simply an ordinary member of the system. The system has “roles” which differ from the role of the therapist. The therapist’s role is defined as a “helper role”. He or she thus operates in a dualistic fashion, by being part of the system as well as being a “helper” or assisting the system. The therapist also operates on a different logical level than the rest of the system, because he or she observes the basic circular patterns in existence as well as their effects on the system. This enables the therapist to observe from a second-order perspective (meta-perspective) and thus communicate about communication. He or she can thus function as an agent of change (Vorster, 2003).

Because the therapist becomes part of the family, Vorster (2003) also highlights his or her role as that of a “trained observer”. Although the therapist might be subjective

in his or her observations, he or she has been trained to see and hear from within a trained frame of reference and to do so in an orderly and systematic fashion.

### ***2.2.3.3 On-going training of the psychologist***

According to Nel (1992), the training system can be viewed as an evolving relational system, thus implying that it is in a constant process of change and development. This implies the restructuring of its content and includes new materials in training. Nel (1992) suggests that this restructuring is due to the following circular processes inherent in training systems:

- on-going research and the self-development of trainers
- continuous feedback and evaluation provided by trainers
- continuous feedback and evaluation provided by trainees
- feedback from discussions with trainers from other training programmes

General systems theory, which is the training programme followed by the Department of Clinical Psychology at Medunsa, will now be discussed.

## **2.3 GENERAL SYSTEMS THEORY**

The next section deals with general systems theory (GST) and factors such as background and development, as well as the concepts of the theory.

### **2.3.1 Background and development**

In this study, the psychiatric institution will be presented as a particular variation of a social system. It is therefore necessary to look at general systems theory (GST) and its assumptions, which underlie the theoretical foundations of this study.

GST was first proposed by the biologist Ludwig von Bertalanffy in the 1940s. The theory represents an effort to provide a comprehensive theoretical model embracing all living systems - a model relevant to all the behavioural sciences. Von Bertalanffy's major contribution is in providing a framework for looking at seemingly unrelated phenomena, and understanding how together they represent the interrelated components of a larger system (Goldenberg & Goldenberg, 1991). Von Bertalanffy's envisioned a general systems theory that would be all-inclusive and would clarify the principles common to all kinds of systems, be it animal or human, living or mechanical. Von Bertalanffy developed the theory to act as an interdisciplinary set of guidelines. He elaborated on principles and models that apply to all systems in general (Tyler, 1992).

A system consists of various parts of subsystems which are related and interact simultaneously and mutually. These subsystems interact with each other via horizontal transactions, and with the system as a whole by means of vertical interaction. Each subsystem impacts on other subsystems and the whole system (Visser, 2006; Bosman, 2004; Vorster, 2003). The theory does not view the parts as being isolated and simply adding the parts to make up an entity, but emphasises the

relationships between the parts (Goldenberg & Goldenberg, 1991). Every aspect of a system is defined as part of a complex whole, directly or indirectly connected to everything else (Visser, 2006).

According to Vorster (2003) the implication here is that in a therapeutic context, the therapist begins interacting with the identified client and the former becomes inextricably part of the identified client's system. In a psychiatric hospital, this refers to the psychologist becoming an inextricable part of the "in-patient's" system.

According to Moore (in Meyer *et.al.*,2003), Von Bertalanffy's general system theory played a particularly important role in psychology's movement away from a reductionist to a holistic view.

The traditional reductionist view of a system explains complex phenomena by breaking them down into a series of less complex cause-and-effect reactions, by using a linear method of how A causes B, B causes C, and so forth. According to Goldenberg and Goldenberg (1991), GST is based on the notion that it is not the structure that defines an object, but its organisation as defined by the interactive pattern of its parts. Hence, the interrelations are more important than the component parts of a system.

GST is the scientific exploration of "wholes" and "wholeness" which were considered to be metaphysical notions transcending the boundaries of science (Von Bertalanffy, 1968). The concept of "system" constitutes a "new philosophy of nature", namely developments in engineering science, which tend to centre around

computer technology, cybernetics, automation and control. However, by focusing on the human element, they have however been extended beyond the purely technological field (Tyler, 1992).

The development of a systems theory for mental health is generally ascribed to Bateson (1972) and his co-workers at the Mental Research Institute in Palo Alto, California. The relationship and interaction between the objects in a system are the main focus of GST. Bateson pointed out that in order to understand an individual's mental illness, one should look at his or her communications and interactions in terms of the larger whole or system. The emphasis thus moves from the intrapsychic processes (inside) the individual to the interpsychic processes (between individuals) (Nichols & Schwartz, 1995). The individual is thus part of a larger system such as a family or group in a mental institution. The family or specific group in a mental institution is also part of the community's supra-system. Systems therefore form a hierarchy of related systems, and human functioning is studied in terms of the interactional patterns within and between these systems and subsystems (Moore, in Meyer *et.al.*,2003).

### **2.3.2. GST Concepts**

Systems theory is based on a few assumptions that need to be taken into account when using the theory. The basic concepts of the theory will now be briefly explained.

### **2.3.2.1 *Definition of a system***

The word “system” comes from a Greek term meaning “to place together”, not at random, but in a particular order. There are several definitions of a system. Note the following two:

- (1) “A system can be defined as any two or more parts that are related, such that change in any one part changes all parts” (Hanson, 1995, p. 27, as cited in Visser, 2006).
- (2) “A system is an organized whole that consists of parts or sub-systems that are interdependent and forms a whole” (Duffy & Wong, 1996, as cited in Visser, 2006).

### **2.3.2.2 *Suprasystem and subsystem***

A system is always part of or embedded in a larger system, namely a suprasystem, with which it interacts. If “patients” in a mental institution were defined as the system, the mental institution (consisting of administration, psychiatrists, psychologists and nurses) would be the suprasystem.

Every system consists of a number of subsystems or parts. These subsystems interact with one another (horizontal interactions) and with the system as a whole (vertical interactions). Every subsystem impacts on other subsystems as well as on the suprasystem (Visser, 2006). Carr (2000) defines a subsystem as a system within a system, separated from other systems by a boundary.

### **2.3.2.3 *Nonsummativity***

Visser (2006) states that a system consists of various parts or subsystems that are related and interact with one another. The interaction between these parts and changes in them affect the system as a whole. The system itself is a unit or a whole that is more than the sum of its parts.

### **2.3.2.4 *Circular causality***

According to Hanson (1995, as cited in Visser, 2006), causality refers to the inference of relationships between things in such a way that the combination thereof brings about a change.

With the development of the systemic perspective, people and events were seen in the context of mutual interaction and mutual influence. Traditional linear thinking, as in the mechanistic/reductionist approach, is characterised by the classical stimulus-response explanation, where A leads to B, B leads to C, C leads to D in a chain of linear causality (Nichols & Everett, 1986).

The focus is not on linear causality in GST, where B can be described as a direct consequence of A, but on reciprocity and shared responsibility. This refers to the circular influence, where A and B exist in a relationship in which one influences the other and both are simultaneously the cause and effect of each other's behaviour (Becvar & Becvar, 1999).

### **2.3.2.5 Feedback**

In Cybernetics, information about change in the system that produces action is defined as feedback (Carr, 2000). Cybernetics suggests that “all change can be understood as the effort to maintain some constancy and all constancy as maintained through change” (Bateson, 2000, p. 17, as cited in Visser, 2006). Feedback about the current functioning of the system goes back into the system and there is a constant change in the form of self-regulation to maintain stability in a constantly changing environment input to determine further action (Visser, 2006).

According to Nichols and Everett (1986), the concept of feedback means that there are two channels carrying information in such a way that one loops back from the output to the input, thus feeding information back into the system that affects the following outputs from the system.

Feedback may be either positive or negative (Goldenberg & Goldenberg, 1991; Vorster 2003). It is regarded as negative when it restores the balance in the system. The status quo is thus maintained, and provides information that decreases the output deviations. Feedback is regarded as positive when it facilitates change in a system in the same direction as is currently occurring. It increases the process of change (Visser, 2006 ; Nichols & Everett, 1986).

### **2.3.2.6 *Morphostasis and Morphogenesis***

Systems theorists use the concepts of morphostasis and morphogenesis to describe a system's ability to remain stable in the context of change, and conversely, to change in the context of stability.

Morphostasis refers to the tendency of a system to maintain itself, despite the influence of the suprasystem, through counteracting deviations (*system constancy*). In order to remain stable, a system must be able to change accordingly (Becvar & Becvar, 1999). Morphogenesis implies that the system develops a new structure in order to adapt itself to environmental pressures, by amplifying deviations, thereby changing itself (system redefinition) (Nicols & Everett, 1986).

### **2.3.2.7 *Open and closed systems***

The extent to which a system screens out or permits the input of new information is referred to as the openness or closeness of that system. Balance between the two is desirable for healthy functioning (Bosman, 2004).

According to Visser (2006), a system is differentiated from other systems and the suprasystem by boundaries. In the social sciences, boundaries may be abstract and relative and defined by the observer. A boundary is an invisible line of demarcation that separates a system, subsystem or individual from outside surroundings. In a system such as a family, boundaries circumscribe and protect the integrity of the system, determining who is considered an insider and who remains outside

(Goldenberg & Goldenberg, 1991). A boundary filters information “entering” and “exiting” the system (Carter, 2003).

The boundary of a closed system is resistant, that is, there is no exchange of energy or information between the system and the environment. For example, a kettle can be regarded as a closed system. A kettle boils water, but its electrical functioning does not change when it is not functioning (Visser, 2006).

Open systems continuously interact with their environment by exchanging energy and information with the environment through permeable boundaries. All living systems are to some degree open systems. An open system is characterised by constant exchange of energy and information in the system and across its boundaries, signifying a process of growth and change (Visser, 2006).

Goldenberg and Goldenberg (1991) disagree with Visser (2006) by stating that in family terms, no system is fully opened or closed: if it were totally open, no boundaries would exist between it and the outside world, and if it were totally closed, there would be no exchanges with the outside environment, and it would die.

#### ***2.3.2.8 Equifinality and Equipotentiality***

GST also rests on the principles of equifinality and equipotentiality.

In the case of equifinality, the final position or result is the same or equivalent, although the initial position may be different (Moore, in Meyer *et.al.*,2003).

This refers to the fact that the same results can be obtained by different means and by starting from different beginning points. Such a system consists mainly of negative feedback loops, because negative feedback counters initial deviations from the balanced position (Visser, 2006; Nichols & Everett, 1986).

In the case of equipotentiality, the original position or potential is the same, while different final situations or effects may be obtained (Moore, in Meyer *et.al.*,2003).

The principles of equifinality and equipotentiality imply a dynamic process in which different “paths” can lead to similar destinations, and similar starting points can conclude in completely different final situations (Moore, in Meyer *et.al.*,2003).

#### **2.3.2.9 Rules of a system**

A system operates according to certain rules that can be expressed in terms of characteristic patterns in a system. These rules express the values of the system and the prescribed roles of behaviour in the system (Becvar & Becvar, 1999). The rules and roles help maintain stability in the system. These rules distinguish one system from another (Becvar & Becvar, 1999).

It is necessary to grasp the development of a system’s norms and rules so that their role in shaping the conformity of individual behaviour, in terms of rules in the system, can be highlighted.

### **2.3.2.10 *Communication***

Open systems are in a dynamic state when the relationship between components is maintained by various potential and actual interactions. These interactions can be regarded as the exchange of information in a system or as communication (Hanson, 1995, as cited in Visser, 2006).

Hanson (1995, as cited in Visser, 2006) points out that the focus should not be only on content or direct modes of communication in order to understand the meaning thereof, but also consider the relationship between what is said and what is meant, and how this prescribes behaviour.

Adler, Rosenfeld and Towne (1983, p.18) define communication as follows:

Communication is a continuous, irreversible, transactive process involving communicators who occupy different but overlapping environments and are simultaneously senders and receivers of messages, many of which are distorted by physical and psychological noise.

Communication is a relationship, and a relationship is communication. One cannot not communicate (Vorster, 2003). Becvar and Becvar (1999) contend that all behaviour has message value in the context of others. Even silence is a form of communication. Each action in a system does not take place in isolation, but has communication value at a particular logical level, and impacts on all other components of that system (Hanson, 1995, as cited in Visser, 2006).

According to Adler and Rodman (1994), the term “meta-communication” is used to describe messages that refer to other messages. In other words, it is communication about communication. Whenever we discuss a relationship with others, we are meta-communicating: for example, “I wish we could stop arguing so much”.

#### **2.3.2.11 *Process***

Becvar and Becvar (1999) refer to process as change over time. It includes the ongoing functions and history of a system. Process may involve one or more subsystems. The focus shifted from content to process in GST.

#### **2.3.2.12 *Context***

Behaviour cannot be understood without considering the context in which it behavior occurs. Bateson (as cited in Vorster, 2003) emphasised the significance of context with regard to the meaning of words or actions. This was regarded as significant in all kinds of communication. The meaning of a specific type of action changes according to the context. It can therefore be deduced that all behaviour serves as information that provides clues about the nature and functioning of a system (Vorster, 2003).

#### **2.3.2.13 *Summary***

GST provides the theoretical underpinnings for much of current family therapy theory and its practice. The concepts of organisation and wholeness emphasises that a system operates as an organised whole that is greater than the sum of its parts, and

that such a system cannot be adequately understood if it is broken down into component parts (Goldenberg & Goldenberg, 1991).

A systems theory allows us to conceptualise the organisation of these interacting levels. It also helps to direct the therapist in setting the goals for therapeutic intervention. For example, we might not accept a family's view about who the sick person is. A child who refuses to go to school may be best helped by looking at the whole family; the arrival of a new baby or mother's depression may need to be considered in order to help the child. It is necessary to look at the wider system before interpreting the meanings and messages, overt and covert, which the client is conveying or to which the client is responding (Bateman, Brown & Pedder, 2000).

#### **2.4 THE PSYCHIATRIC INSTITUTION AS A SOCIAL SYSTEM**

It is necessary to illustrate that the principles governing systems in general are the same principles that govern the social system (Carter, 2003).

GST states that the components of all "systems within systems" exchange energies. It can therefore be postulated that individuals, as components of the social system, are affected in the same manner. Hence individuals cannot not behave or communicate (Watzlawick, Bavelas & Jackson, 1967). To behave with maximum effect, individuals must optimise their relationships with others through a sequence of messages known as interaction. This ongoing process of interaction or particular sequences of communication are repeated between individuals or used in different contexts with other individuals in proximity to each other. This results in the

development of a “pattern” of regular behaviour in which individuals may participate. This network of common patterns of interaction, consisting of the interaction of individuals, is referred to as a social system.

A social system exists because of its set of interrelated statuses and roles. This implies that a social system shares certain basic structural properties with all types of systems (Popenoe, 1983).

For the purpose of this study, a social system is defined as a combination of social relationships existing within a certain boundary.

One variation of the social system, namely the psychiatric institution, is discussed below.

#### **2.4.1 A historical perspective of the psychiatric institution**

According to Makgatho (2000), the history of the caring process of mentally ill people in the USA and the UK reflects not only changes in the scientific understanding of mental disorders, but also takes the political, social and economic philosophies of the times into account.

During the Renaissance period, humankind came to understand that people become mentally ill for natural reasons and require medical attention. This period thus saw the creation of specific asylums for the mentally ill. The function of an asylum was to segregate and contain the mentally ill. Since no medical treatment was provided, these institutions were not hospitals in the modern sense of the word (Gillis, 1986).

In the 16<sup>th</sup> century, the scientific discoveries of humankind (e.g. Galileo and Newton) were extended to psychiatry. This was a slow process and mentally afflicted people were still not regarded as being sick. Insanity was viewed as a problem with social and spiritual, as opposed to medical implications. Mental illness was thus not regarded as a medical condition (Makgatho, 2000).

Treatment consisted of waiting for the symptoms to abate or the application of more extreme measures such as blood-letting and starvation. The conditions in public mental institutions in the early 1800s continued to be abysmal. “Patients” were chained in cells or locked up together. When it was realised that the environment of “patients” was linked to the outcome of their treatment, reforms relating to their confinement (lock-up) were introduced. On 25 August, 1793 Philippe Pinel insisted on unchaining the “patients”, thereby “revolutionising” the treatment of mental “patients” (Gillis, 1986).

Mental institutions were established as a form of shelter for the mentally ill. They were the only sheltered places in which the mentally ill could be kept away from society without problems (Makgatho, 2000). The psychiatric institution has not always provided effective care and rehabilitation for “patients”. In some instances, it can even be considered as iatrogenic or causing illness, which in fact leads to greater harm (Baumann, 2007). This was often observable in the manner in which relationships between psychiatric staff and “patients” were conducted. The history of the psychiatric institution has resulted in institutions being described as “user-unfriendly” and disempowering, owing their tendency to “medicalise” and alienate

the people they should serve. Bauman (2007) holds that medicalisation leads to unnecessary labelling and inappropriate investigation and treatment.

According to Baumann (2007), the first hospital established for “mentally deranged” individuals in South Africa was in 1711. The next institution to offer care for the “insane” was in the Somerset Hospital in Cape Town in 1818. In 1846, the prison colony on Robben Island was converted to the Robben Island Infirmary, specifically for “lunatics and chronically ill” “patients”. Other asylums were established in the following years, for example, Town Hill in Pietermaritzburg, Fort England in Grahamstown, Valkenberg in Cape Town and the Pretoria Asylum.

There are 24 registered public psychiatric hospitals in South Africa, accommodating some 14 000 acute and long-term care “patients”. The idea is to establish community-based psychiatric services and integrate mental health services into primary health care (Baumann, 2007).

#### **2.4.2 A systemic definition of the psychiatric institution**

The term “psychiatry” is derived from two Greek words meaning “mind-healing” and this is what it deals with – not only gross mental disorders, but also the emotional and psychological factors which disturb people’s peace of mind (Gillis, 1986).

A psychiatric hospital can be defined as a facility that provides acute 24-hour inpatient care for mentally disordered and incompetent “patients”. Such care shall include, but is not limited to, the following basic services: psychiatry, clinical

psychology, psychiatric nursing, social work, rehabilitation, drug administration and food service (American Psychological Association, 1997).

Cockerham (1996) describes a psychiatric institution as a “total institution”, which he defines as a place of residence and work where a large number of like situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed formally administered round of life. The psychiatric hospital becomes a home to “patients” and contact with this community increases. The “patients” form a new community/system. This system’s relationships often resemble those found in a family system.

The psychiatric institution can be described as a therapeutic community comprising of interrelated psychiatric wards. The relationships in a therapeutic community have a balance similar to those found in a family system (Carter, 2003).

Talbot (1980, p. 109, as cited in Carter (2003), goes further, describing the state psychiatric hospital as “... a dynamic decision system that must analyze constantly changing current data and integrate it with the overall objectives of the organization. In this regard, it is useful to consider the total hospital organization as a communication network.”

In order to treat abnormal behaviour, the therapeutic communities in the mental institutions provide a useful matrix for psychiatric treatment. A therapeutic community is an association of “patients” and staff who jointly create a small system within a hospital which facilitates interpersonal interactions and personality growth

(Gillis, 1986). All “patients” require psychotherapeutic support and understanding. This enables the majority of the “patients” to come to some degree of acceptance of their illness. They adopt coping strategies and defences that prevent the development of continuing dependency on a mental institute (Maxwell, 1993).

For the purposes of this study a psychiatric hospital can be defined as an institutional facility in which interactions between “patients” and staff form networks of relationships. These networks function as systems within systems, some of which have a distinct therapeutic function. In these selected subsystems or wards, staff-patient interaction is utilised to modify patient behaviour so that it (the patient’s behaviour) complies with the treatment objectives of staff and institution, as well as the social norms of the institution and the larger community (Carter, 2003).

The psychiatric institution functions as an organised system at various levels. This view provides a significant context in which to study and understand the behaviour of the individual psychiatric “patient” participating in staff-“patient” relationships in the psychiatric institution. It is therefore necessary to consider how this system impacts on individuals accepting their “patient” roles, admission to the psychiatric institution, diagnosis and treatment (Carter, 2003).

### **2.4.3 Psychiatric intake/hospitalisation**

The admittance of a “patient” to a psychiatric institution has profound effects on the individuals concerned. Research has shown that owing to the tendencies of closed

institutions to depersonalize individuals, vulnerable people could be damaged (Rose, 1997).

The complexity of this process can lead to the individual exhibiting certain role repertoires in the context of the psychiatric set-up. This may include what Sadock and Sadock (2007, p. 4) identifies as *illness behaviour*, which is “...the patients reactions to the experience of being sick”. Aspects of illness behaviour have sometimes been termed the sick role, that is the role society ascribes to people when they are ill.

#### **2.4.3.1 Admission to a psychiatric institution**

Admission to a psychiatric hospital has an administrative and social impact on the “patient”, which is discussed with reference to the USA and South Africa.

The American Bar Association has endorsed four procedures of admission to psychiatric facilities in order to safeguard civil liberties and protect a person from being forced into a psychiatric institution. These four procedures are informal, voluntary, temporary and involuntary admission (Sadock & Sadock, 2007).

In South Africa, admission to a psychiatric institution is governed by the Mental Health Care Act 17 of 2002, which replaced the Mental Health Act 18 of 1973. The overall aim of the Act is to regulate the mental health environment in order to provide mental health services in the best interests of the patient (Baumann, 2007).

Baumann (2007) highlights the definitions in the Act as follows:

- voluntary care: the provision of health interventions to a person who gives informed consent to such interventions
- assisted mental care: provision of care to those incapable of making informed decisions owing to mental illness and who do not refuse treatment and interventions
- involuntary care, treatment and rehabilitation: provision of care to those incapable of making informed decisions due to mental illness, and who refuse treatment and who require treatment either for their own health and safety or for the protection of others

Admitting a “patient” to a psychiatric institution requires a diagnosis or the knowledge of a person’s mental health status. This officially classifies the “patient” as “sick” and thereby requires admission to a psychiatric institution, depending on the severity of the diagnosis.

#### ***2.4.3.2 Psychiatric diagnosis***

Systems of classification for psychiatric diagnoses have several purposes: to distinguish one psychiatric diagnosis from another, in order to provide the most effective treatment, as well as to offer a common language between health care professionals (Sadock & Sadock, 2007). The two main psychiatric classifications are the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), developed by the American Psychiatric Association, and the International Classification of Diseases (ICD), developed by the World Health Organization (WHO).

In clinical psychiatry, the psychiatrist first determines if a mental disorder is present – the diagnosis – before assessing the “patient’s” mental function, behaviour, social circumstances and personality (Goldman, 2000).

Goldman (2000) suggests that a diagnosis of a mental disorder is a type of “shorthand”, for defining an individual’s problems in a way “patients”, doctors and society will recognize.

According to Reed and Lomas (1984), a diagnosis can be interpreted as an instrument for legitimating social control of deviant individuals or the mentally “ill”. Diagnosis has an ambiguous significance for the “patient” – it can be regarded as a ticket to the privileges of the sick role, but also as something which stigmatises the “patient” with the label of mental illness.

Baumann (2007) states that psychiatric disorders are universal, but their presentations and the social value attached to them are all shaped by cultural factors. The current major international systems have their roots in the USA and Europe, which embody a Western world-view and not that of a Third World country like South Africa. Diagnosis in Third World “patients” raises special difficulties. Extreme caution must be exercised to avoid an incorrect diagnosis (Schlebusch, 1990). Baumann (2007) holds the opinion that the situation in South Africa is compounded by the increasingly changing social and cultural landscape, generated by the combined effects of political transformation, urbanisation, migration and the impact of globalisation.

Although the classification system has advanced psychiatric diagnosis in diagnosing “patients”, it should be recognised as one tool among many. Hence no classification system can be applied without adequate clinical training and judgment (Goldman, 2000).

For the purposes of this study, a psychiatric diagnosis is defined as the use of agreed-upon medical conceptual frameworks for the purposes of classifying and treating mental illness (Carter, 2003).

The DSM-IV-TR helps the psychiatrist to make an accurate diagnosis of the person’s mental disorder to facilitate the effective treatment of him or her, in a psychiatric institution. Sadock and Sadock (2007) elaborate on this by stating that the diagnosis of disorders is vital in determining the best therapeutic approach.

#### ***2.4.3.3 Treatment in psychiatric institutions***

The most useful treatment approaches are developed in the framework of the biopsychosocial model, namely at physical, mental and social levels. Different treatment approaches may be useful at different times over the course of a “patient’s” illness (Goldman, 2000).

The biopsychosocial model combines generic and specialist health care with assessment and therapeutic interventions. It moves away from a fragmented and traditionally medically dominated model to more comprehensive care focusing on the holistic person (Baumann, 2007). This model addresses social intervention. Social intervention is aligned with systems theory, which is consistent with biopsychosocial

approaches. The systems theory provides an account of how people impact on and in turn are impacted upon by their environment. This leads to stresses because of the disequilibrium in the system.

Hospital settings offer a wide variety of treatment options, including medical treatment; group, individual and family psychotherapy; social worker services; and occupational and recreational activity therapies. According to Goldman (2000), the treatment plan should ideally be tailored to meet the medical, social and psychological needs of each patient. The formulation of a treatment plan is based on information from a psychiatric interview, administration of a mental status examination (MSE) and the ordering of laboratory tests for possible organic causes of pathological behaviour (Sadock & Sadock, 2007). The treatment plan thus specifies the specific therapeutic intervention, for example, medication and psychotherapy.

Medication should not be used in isolation but as part of a comprehensive management plan, which includes psychological and social components as explained by the biopsychosocial model. In order to improve the successful treatment of medicine, “patients” should be given sufficient information and encouraged to participate actively in their treatment (Baumann, 2007).

Multidisciplinary teams of mental health professions function in a psychiatric institution. The psychiatrist usually leads the team, while the nurse manages day-to-day ward activities and medications and monitoring of “patients”. The clinical psychologist normally performs tests and handles the therapy either individually or in

groups. The social worker arranges for the financing of hospital care and post-hospital care, while the occupational therapist arranges activities for the “patient” during his or her hospital stay (Goldman, 2000). This set-up obviously differs in different psychiatric institutions.

The treatment and experience of being in a psychiatric institution may be complicated for the “patient”. Several disruptions and limitations are encountered in hospital life that can have numerous negative effects on the “patient”. These effects will subsequently be described under the headings of psychological effects and the hospital environment.

The psychological effects of being treated in a psychiatric institute have an impact on the “patient’s” physical and social environment. With regard to the physical environment, it is obvious that the move to a psychiatric institution implies a profound change for the “patient”. There are relatively few studies on how the physical environment of the hospital affects the “patient’s” condition (Weinman, 1987).

The social environment pertains to how the individual’s privacy is intruded upon. “patients” often see the hospital environment as drab, clinical, impersonal and cold. The daily routine of the “patients” is likely to be totally different from their lives at home. They may also experience a loss of independence and individualism, as well as reduced opportunities for social contact (Weinman, 1987; Schlebusch, 1990).

Some “patients” may require a longer stay in a psychiatric institution. The social and physical environment of the institution will have long-term effects on the “patient’s” behaviour and feelings. A unique feature of a psychiatric institution is that the individual has to adhere to the way of life in such a organisation and penalties are imposed on those who fail to do so. Past studies of institutionalisation highlighted the neglect, indifference and dehumanisation “patients” have to endure. These environments did not result in positive therapeutic changes, but were often counter-therapeutic and did not lead to the psychotherapeutic growth of the “patients”. It was found that lengthy stays in a psychiatric institution produced social withdrawal, apathy, loss of contact with reality and a resistance to discharge. All of these made it more difficult for the “patient” to adapt to life outside the hospital (Weinman, 1987; Schlebusch, 1990).

According to Weinman (1987), the management of hospitals are more concerned with the smooth running of the organisation than the emotional needs of individual “patients”. Weinman (1987) furthermore states that if there is a clash between management and a “patient”, it is likely that the “patient’s” needs will not determine the outcome. If “patients” do not conform to the routine in the institution, there will be problems in management, which could be classified as antisocial or obstructive behaviour on the part of the “patient”. This could result in compulsory detention, seclusion and social, physical or chemical restraints.

One of the principal factors in a psychiatric institution, is the quality of the staff-“patient” interactions. Staff who tend to be controlling, inaccessible and authoritarian,

appear to create a social environment detrimental to “patients”. If the staff mingle with the “patients” and if they are perceived to be empathic and supportive, this could result in a social atmosphere in which change is more likely to occur in the “patient” (Weinman, 1987).

## **2.5 “PATIENT” MANAGEMENT AND COMPLIANCE**

With regard to a social system such as the psychiatric institution, the subsystems are also subject to the principles of GST. A subsystem of the psychiatric institution is the staff-“patient” relationship. This specific relationship is subject to, *inter alia*, the various feedback loops.

An example of such a feedback loop is the psychiatric diagnostic decision-making process on the psychiatric “patient”. These decisions are underpinned by the information gained from observations of staff-“patient” interaction. This feedback process from a psychiatric punctuation is characterised by the information flow between staff members, who are deemed “experts” and the “patients”, who are “nonexpert” participants, at the treatment level of the relationship (Sadock & Sadock, 1998, as cited in Carter, 2003).

This factor plays a crucial role in understanding the compliant behaviour between staff and “patients”.

### 2.5.1 “Patient” management

The interaction between staff and “patients” can be observed in staff-patient relationships (Vorster, 2003 as cited in Carter, 2003). The repetition of these messages results in the development of communication patterns as highlighted below, (Vorster, 2003):

- *The complementary relationship.* In a complementary relationship the behavior of one partner complements that of the other partner in the sense that one partner is in a one-up position and the other in a one-down position (leader and follower).
- *The symmetrical relationship.* Here similar behaviours are set against each other, which is essentially a struggle (unsuccessful) to ensure an equal position in the relationship.
- *The parallel relationship.* This is a relationship between equals.

According to Carter (2003), although “patients” in a psychiatric institution have the potential for a variety of relationship definitions, the complementary relationship definition is the predominant pattern exhibited. This is evidenced by staff being the “expert” (hence in the one-up position) and the “patient” being the “nonexpert” (thus in the one-down position).

### **2.5.2 Power, control and “patient” compliance**

The management of “patient” behaviour depends largely on the ability of the staff member to orient a “patient” towards accepting the complementary definition of his or her relationship (Sadock & Sadock, 1998).

Hence variables such as power and compliance are of paramount importance in the interaction between a staff member and “patient”. Power can be defined as the degree to which the actions of an individual influence the behaviour of another, in a given context (Rosenbaum, 1983).

Punctuating from a systemic point of view, the power in a staff-“patient” relationship, appears to lie in the ability of one party, usually the staff member. The staff member effectively regulates the information flow within that system, leaving the “patient” in the one-down position (Carter, 2003).

This leads to the staff member being able to elicit compliant behaviour from the “patient”. Haynes, (1979, as cited in Sharif, 2000, p. 30) defines compliance as follows: “Compliance is the extent to which a person’s behavior (in terms of taking medications, following diets or existing lifestyle changes) coincides with medical or health advice.”

Bond and Lader, (1969, as cited in Mngoma, 2001) report that compliance is a key factor in any treatment procedure, and that noncompliance may lead to a mistaken assumption about the treatment inefficacy. Compliance is fostered when the staff/doctor-“patient” relationship is a positive one (Sadock & Sadock, 1998).

From a psychiatric point of view, the “patient’s” acceptance of the definition as being complementary is crucial to “patient” management and thus compliance as well (Carter, 2003).

### **2.5.3 Enforcing compliance**

It is possible for the staff members to use their one-up position in the complementary relationship to elicit some degree of compliant behaviour. One can deduce that some “patients” may benefit therapeutically from this definition. However, this does not account for all “patients”. According to Sharif (2000), studies show that “patients” tend to comply with treatment between approximately 31 and 54% of the time when receiving treatment in psychiatric care.

This is indicative of the noncompliance of “patients”. Bond and Lader, (1996, as cited in Mngoma, 2001) define noncompliance as the failure to collect or buy the prescribed medicine from the chemist. Noncompliance is also influenced by the attitude of the doctors prescribing the medication and the professional nurses who administer the medication in the psychiatric institution. Noncompliance also refers to the failure to follow other treatment programmes such as psychotherapy, whether individually or in a group (Mngoma, 2001).

The treatment “failure”, from a psychiatric perspective, can be regarded as the result of either patient noncompliance (individual pathology) or ineffective “patient” management. “Patients” who exhibit “deviant” behaviour, can be regarded as being in a struggle for control or power. This leads to the staff and “patients” being

entrapped by this frame of reference, which results in escalated struggles for control that require staff members to enforce strict procedures to ensure “patient” compliance (Carter, 2003).

At this stage it is necessary to discuss the impact of the “patient’s” compliance with psychological growth in mentally ill “patients”.

## **2.6 MENTAL ILLNESS AND PSYCHOTHERAPEUTIC GROWTH**

It is not possible to outline what mental illness entails before defining the concept of mental health and psychotherapeutic growth.

### **2.6.1 What constitutes mental health?**

It is difficult to define exactly what constitutes mental health. The human mind is complex and human behaviour is diverse. According to Gillis (1986), mental health is more than the absence of the symptoms of disease. Mental health could be described as a positive state which exists in its own right and which could be best described by what it does rather than what it is – hence in behavioural terms.

The WHO considers “normality to be a state of complete physical, mental, and social well-being” (Sadock & Sadock, 2007, p. 12). This indicates that mental well-being presumes the absence of mental disorders as defined in the DSM-IV-TR.

Tilbury (2002) identifies three elements that constitute mental health:

- (1) *The idea of the mature self.* This relates to the type of person one is. A person who is mentally healthy will enjoy his or her life and be satisfied with it. He

or she will have a positive self-image but will also be realistically aware of his or her limitations. This person will have the capacity to learn and develop, which is necessary to maintain mental health, should his or her life circumstances change.

(2) *Self-management in social relations.* This implies the ability to make and sustain intimate relationships. The essence of a healthy capacity to relate would appear to be an ongoing relationship with a person. This leads to the notion of autonomy, of being in control of oneself and one's circumstances. According to Tilbury (2002), a mentally healthy person is not at the mercy of his or her inner needs, desires or feelings, and is able to control, express and direct them in a socially constructive way.

(3) *The discharge of social roles.* This could involve a link from home-based life to work-related functions or to recreation/interest activities. An effective role performance will depend on one's capacity to meet the obligations of that role, together with the ability to adjust that performance.

Criticism has been leveled against mental health definitions, but one should bear in mind that these definitions are typically specific to a particular culture. The above-mentioned definitions were drawn from Western democratic societies.

According to the African concepts, health and illness are generally attributed to factors outside the individual. A concept of mental illness does not exist in the setting of providing mental health services. Traditional healers play a significant role in health care provision in South Africa, and are currently being recognised in the

HPCSA (Health Professional Council of South Africa). This could be beneficial to form a partnership between health care professionals and traditional healers.

### **2.6.2 What constitutes mental illness?**

Mental illness is an extremely complex phenomenon and as a result, mental conditions may go untreated or unrecognised for months, or even years. The generally accepted notion is that “patients” with mental illness have impairments in their mental state, in their perception of reality and inappropriate feelings. This is reflected in their behaviour which may be disorganised, inappropriate, aggressive and bizarre (Makgatho, 2000).

Gillis (1986) contends that mental illness is often deemed to be something strange, remote and deadly serious. It is frequently surrounded by an aura of mystery and attitudes of shame and disgrace.

The term “mental illness” is used freely by clinicians and the general public to refer to a series of conditions, ranging from strange and odd behaviour to a serious psychiatric disorder. The DSM-IV-TR provides the following clinical definition of mental illness (Sadock & Sadock, 2007, p. 15):

“ ... a behavioral or psychological syndrome or pattern associated with distress (e.g. a painful symptom) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, the syndrome or pattern must not be merely an expected and culturally sanctioned response to a particular event, such as the death of a loved one”.

Mental illness is used differently in legal and clinical contexts. According to Barlow and Durand (2005), it is a legal concept, which indicates severe emotional or thought disturbances that impact negatively on individual's health and safety.

Mental illness is not synonymous with psychological disorder, for this implies that receiving a DSM-IV-TR diagnosis does not necessarily mean that a person's condition fits the legal definition of "mental illness". Baumann (2007) further states that the legal use of the term mental illness, refers to any serious psychiatric disorder that significantly interferes with the individual's capacity to perform a given juridical task, such as standing trial. The courts thus make the final determination whether an accused party is mentally ill.

In South Africa, only the Mental Health Care Act 17 of 2002 provides a legal definition of mental illness, namely (Baumann, 2007, p. 561): "... a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health practitioner authorized to make such a diagnosis".

The psychiatrist, Thomas Szasz, had a controversial view of mental illness. He believed that the concept of mental illness should be abandoned, and stated in his book, *The myth of mental illness*, that normality can be measured only in terms of what a person does or does not do. He goes on to say that defining normality is beyond the sphere of psychiatry. Psychiatry has been severely criticised by certain groups over the years, because of its description of normality (Sadock & Sadock, 2007).

### 2.6.3 Psychotherapeutic growth

Mental disorders are usually characterised by impairment in multiple areas (psychological symptoms, impaired life functioning, etc.). The psychotherapeutic progress, which aims to reduce these impairments, should therefore also constitute a multidimensional phenomenon, including improvement in different dimensions.

Howard, Lueger, Maling and Martinovich (1993, as cited in Stulz & Lutz, 2007) introduced a phase model of psychotherapeutic outcome. Stulz and Lutz (2007) introduced three dimensions of the phase model of psychotherapeutic outcome – well-being, symptom distress and life functioning. Howard *et.al.*, (1993, as cited in Stulz & Lutz, 2007) posit sequential improvement in the following areas of change: a *first change of remoralisation* is characterised by the lessening of hopelessness (pessimism). Hopeful and optimistic expectations are held about the benefits of therapy, which could result in the improvement of the “patient’s” subjective feelings of well-being.

In the *second phase of remediation*, symptom reduction is achieved when a positive therapeutic alliance has been established. The “patient” should be able to activate existing or learnt new coping skills.

The *final phase of rehabilitation* involves the adjustment of long-standing and maladaptive patterns of living and the construction of new ways of dealing with various aspects of life and self, resulting in an improvement of life function (Howard *et.al.*, 1993, as cited in Stulz & Lutz, 2007).

Stulz and Lutz (2007) emphasise the fact that one should note that psychotherapeutic progress and growth are heterogeneous issues, and “patients” are expected to differ from one another with regard to change in the above-mentioned three dimensions.

Maslow, the founder of the humanistic movement, refers to change as growth. He acknowledges the positive aspects of human nature – the person’s dignity and active will to develop. According to Maslow, the tendency towards self-actualisation is the motive underlying all behaviour. Realising one’s true potential is one’s ultimate goal. Maslow explained human behaviour in terms of need gratification. People have certain needs, which are hierarchically arranged. These needs are biological, safety, love and esteem needs. These needs must be satisfied before the need for self-actualisation can be satisfied. At this stage the drive to grow become a vital part of the individual. Self-actualisation is the process of becoming all that one is capable of being, by making full use of one’s abilities, talents and potential (Moore in Meyer *et.al.*, 2003).

With regard to psychotherapy, it is important to note that Maslow did not practise as a therapist and he did not propose a therapeutic technique. He commented on the atmosphere that should be created in the therapeutic context, and on the role fulfilled by the therapist in this process. The therapist should facilitate the growth process of the client (Moore, in Meyer *et.al.*, 2003).

The growth process is lacking in “patients” in a psychiatric institution and this will be illustrated on the basis of the film, *One flew over the cuckoo’s nest*.

## **2.7 A DESCRIPTION OF *ONE FLEW OVER THE CUCKOO'S NEST***

This classic film has huge potential for training purposes in a clinical context.

However, it has never actually been analysed and described in a training context.

This film was made in 1975, and was directed by Milos Forman. It is an adaptation of the 1962 novel *One flew over the cuckoo's nest*, by Ken Kesey. The movie was filmed at Oregon State Hospital in Salem, Oregon (Amazon.com.reviews, accessed on 14 July, 2008).

Attitudes to psychiatry and mental hospitals change over time and often reflect the ambivalent feelings about psychiatric institutions. It is therefore necessary to investigate the system in a psychiatric set-up, in order to evaluate the mentally ill "patient's" environment, and his or her place in it. The appropriate environment is simply that which best meets the needs of the "patient" at that particular time and promotes his or her psychotherapeutic growth (Tilbury, 2002).

The setting of the film is a mental hospital in the Pacific Northwest of the USA, where the interactions of the "patients" are observed in a psychiatric system.

Randle Patrick McMurphy (portrayed by Jack Nicholson) is a criminal serving a short prison term on a work farm for statutory rape. He is transferred to a mental institution because of his apparently deranged behaviour. He had decided to declare himself insane in order to serve the rest of this term in relative comfort and ease.

The institution is dominated by Nurse Ratched (portrayed by Louise Fletcher), a cold, precise woman with calculated gestures and a mechanical manner. She intimidates the “patients”, most of whom are there by choice (categorised as “voluntary” “patients”) into miserable submission. McMurphy initially has little respect for his fellow “patients”, but his sense of injustice at their treatment leads him into a battle for the hearts of the “patients”. The question remains just how sane any of the players in the ward actually are. McMurphy fits in extremely well, and his unconventional point of view actually begins to cause some of the “patients” to progress.

Nurse Ratched becomes his personal cross to bear because his resistance to the hospital routine gets on her nerves. McMurphy only later discovers that Ratched has the power to keep him there indefinitely. Instead of having him transferred, Ratched sees his behaviour as a personal affront and challenge to her authority and becomes obsessed with winning the contest.

Throughout his stay at the hospital, McMurphy forms deep friendships with two of his fellow “patients”, Billy Bibbit (portrayed by Brad Dourif) and “Chief” Bromden (portrayed by Will Sampson). Billy is a suicidal stuttering and helpless young man who Ratched has humiliated and dominated. McMurphy sees Billy as a younger brother figure who he wishes to teach to have fun. “Chief” Bromden is a 1,96 metre muscular Native American with schizophrenia. The inmates and staff assumed he was deaf and unable to speak. He is generally ignored, but also respected for his

enormous size. Bromden becomes McMurphy's only real confidant, because they both see their struggle against authority in similar terms.

McMurphy, Chief and Charlie Cheswick (portrayed by Sydney Lassick) are detained for being involved in a fight with the ward attendants. Cheswick undergoes electroshock therapy, while McMurphy and Chief await their turn. McMurphy discovers that Chief can talk, illustrating his hate for the hospital establishment. Chief remains mute in an effort to handle Ratched and the system in the institution. McMurphy then lets Chief in on his plan to escape. After McMurphy has undergone the electroshock therapy, he jokingly feigns catatonia before assuring his inmates and Nurse Ratched that the attempt to subdue him did not work.

On the night of 10 December 1963, McMurphy sneaks into the nurse's station and calls his girlfriend (Candy) to bring booze and assist in his escape. She brings a girlfriend along. The "patients" drink while Billy flirts with McMurphy's girlfriend. He convinces her to sleep with Billy, while the rest of the "patients" are passed out from drinking, probably because of the effect of the neuroleptic drugs in their systems.

The next morning, Nurse Ratched orders the "patients" to clean up and conduct a head count. Billy is found in a room sleeping with Candy, and announces that he is not ashamed of what he has done, whereupon Nurse Ratched threatens to tell his mother. He begs her not to. Billy breaks down and kills himself by slitting his throat in the doctor's office. McMurphy explodes in a violent rage and strangles Nurse

Ratched until she is almost dead. McMurphy is subdued and taken away, and is given a lobotomy as punishment.

Chief Bromden sees McMurphy being returned to his bed. When the Chief approaches him, he discovers that he has been given a lobotomy. Unwilling to leave his neurologically disabled friend behind, the Chief suffocates his friend with a pillow. The Chief then follows McMurphy's plan for escape by hoisting a heavy hydrotherapy control panel through a barred window. He escapes from the institution, fulfilling McMurphy's escape plan for himself (Amazon.com.reviews, accessed on 14 July, 2008 ; Wikipedia-*One flew over the cuckoo's nest*, accessed on 14 July 2008).

## **CHAPTER 3**

### **THE INVESTIGATION**

#### **3.1 INTRODUCTION**

This chapter deals with the research design and method utilised in the study. However, the question whether a quantitative or qualitative approach should be utilised, will first be addressed.

#### **3.2. QUANTITATIVE VERSUS QUALITATIVE RESEARCH DESIGNS**

According to Durrheim (1999, as cited in Terre Blanche & Durrheim, 1999) a research design is a strategic framework for action that serves as a bridge between research questions and the implementation of the research. Durrheim (1999, p. 29) further states that research designs are plans that guide “the arrangement of conditions for collection and analysis of data in a manner that aims to combine relevance to the research purpose with economy in procedure.” Mouton (2001) summarises a research design as a plan or blueprint of how the researcher intends conducting the research. Since research designs are tailored to address different kinds of questions, a specific design type is chosen according to the kind of questions it is able to answer (Mouton, 2001). Two research designs will be discussed below, namely the quantitative and qualitative approaches.

### **3.2.1 Quantitative research**

Quantitative research refers to studies whose findings are mainly the product of statistical summary and analysis. Quantitative data consist of numerical information, such as scores on a test or the frequency with which a behaviour occurs (Whitley, 2002; Brannen, 1992, as cited in Carmichael, 2001).

Palys (1997) defines quantitative approaches as research methods that emphasise numerical precision. In this approach the researcher adopts a more detached aloof stance (i.e. the avoidance of overidentification). Palys (1997) goes on to say that by overidentifying with their study, researchers sometimes become so attuned and sensitive to the culture or group they are investigating that they take on the perspective of the group's members, leaving their analytical perspective behind. Neuman (2000) also justifies this aloof stance by stating that quantitative research generally assumes that a researcher conducts research independent of the social context, thus achieving objectivity.

The purpose of quantitative research is to measure units of reality, linear and cause-and-effect relationships as well as the impact of dependent and independent variables in experimental contexts. Quantitative research isolates and defines variables and variable categories. These variables are often linked together to form a hypothesis, usually before any research has been conducted (Brannen, 1992, as cited in Carmichael, 2001; Neuman, 2000).

Quantitative methodology is used to investigate the social world in ways which imitate the “scientific method” as used in the natural sciences. The emphasis is on hypothesis testing, causal explanations, generalisations and predictions. The quantitative approach is useful for obtaining “hard” data based on causal explanations in order to verify particular “facts”. Quantitative studies can also produce purely descriptive and inductive statistics (Ritchie & Lewis, 2003).

### **3.2.2 Qualitative research**

Qualitative research is used in this study. Denzin and Lincoln (2000, p. 2) define qualitative research as “a multi-perspective approach (utilizing different qualitative techniques and data collection methods) to social interaction, aimed at describing, making sense of, interpreting or reconstructing this interaction in terms of the meanings that the subjects attach to it”. In the second edition of their *Handbook of qualitative research*, Denzin and Lincoln (2000, p. 3) formulates the following definition:

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 ... 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 interpretative, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to

make sense of, or to interpret, phenomena in terms of the meanings people bring to them.

This research process starts by accepting that there is a range of different viewpoints or ways of making sense of the world. It is concerned with discovering and understanding meanings, as seen by those being researched and strives to comprehend their views and perspectives of the world, rather than those held by the researcher (Terre Blanche & Durrheim, 1999). According to De Vos (1998), the qualitative researcher is concerned with

- understanding rather than explaining
- naturalistic observation rather than controlled measurement
- the subjective exploration of reality from the perspective of an insider as opposed to the outsider perspective which is predominant in the quantitative paradigm

Qualitative data consist of non-numerical information, such as descriptions of behaviour or the content of people's responses to questions in an interview (Whitley, 2002). Qualitative research is multimethodical in focus, involving an interpretative, naturalistic approach to its subject matter. 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. Qualitative research involves the studied use and collection of a variety of empirical materials – case study, personal experience, introspective, life story, interview, observational,

historical, interactional, and visual texts – which describe routine and problematic moments and meanings in individuals' lives (Denzin & Lincoln, 2000).

Ritchie and Lewis (2003) highlight key elements of qualitative research. These include the following:

- aims directed at providing an in-depth and interpreted understanding of the social world of the research participants
- samples that are small in scale and purposively selected on the basis of prominent criteria
- data collection methods that usually involve close contact between the researcher and the research participants, which are interactive and developmental and allow for prominent issues to be explored
- data that are very detailed, information rich and extensive
- analysis that is open to emergent concepts and ideas and that may produce detailed description and classification, identify patterns of association, or develop typologies and explanations
- outputs that tend to focus on the interpretation of social meaning through mapping and “re-presenting” the social world of research participants

An inductive, qualitative approach is therefore required if the research aim is to study phenomena as they unfold in real-world situations, without manipulation. The purpose is to study phenomena as interrelated wholes in stead of splitting them into

discreet, predetermined variables (TerreBlanche & Durrheim, 1999). A qualitative approach is adopted in the present study.

### **3.3. RESEARCH DESIGN**

According to Mouton (2001), the qualitative research design involves the entire process of research, from conceptualising a problem to writing the narrative. This process includes the aim of the study, the research question, research methodology, sample group, data gathering and analysis.

#### **3.3.1 Objectives of the study**

The objectives of the study are to

- describe the dynamics of the psychiatric system as depicted in the film
- identify and describe the impact of the systems and/or subsystems on the psychotherapeutic growth of the “patients” as depicted in the film
- provide suggestions for the training of psychotherapists on the basis of the film and the present research.

#### **3.3.2 Procedure**

The necessary research permission will be requested from the MCREC (Medunsa Campus Research Ethics Committee).

The clinical psychologists will be selected on the basis of their schooling in the principles of GST and its application as a meta-theory, which also forms the theoretical framework of this study.

The film, *One flew over the cuckoo's nest* was identified as the appropriate case study for this type of study. The three objectives of the study and a copy of the film will be distributed to the clinical psychologists.

### 3.3.3 Sampling

Sampling refers to the method used to select a given number of people from a population (Mertens, 1998). Qualitative research uses nonprobability samples for selecting the population for the study. In a nonprobability sample, units are deliberately selected to reflect particular features of or groups in the sampled population. The sample is not intended to be statistically representative, but instead, the characteristics of the population are used as the basis of selection (Ritchie & Lewis, 2003). This feature lends itself to small-scale, in-depth studies.

A sample should be selected with a specific purpose in mind. In purposeful sampling, the sample units are chosen because they have particular features or characteristics that make it possible to explore in detail and understanding the central themes (Ritchie & Lewis, 2003).

A case study is an in-depth examination of a single instance of a phenomenon (Whitley, 2002). Jones and Lyons (2004) suggest that a case study consists of an in-depth investigation of a case, which uses a variety of methods to investigate the

phenomenon in question. The “case” can be an individual or a “group case”. Jones and Lyons (2004) further suggests that the “case” is the unit of analysis – the very heart of the study.

VanWynsberghe and Khan (2007, p. 41) define a case study as follows: “The case study offers a means of investigating complex social units consisting of multiple variables of potential importance in understanding the phenomenon”.

Stake (2000, as cited in Luck, Jackson & Usher, 2006) identifies three types of case studies: intrinsic, instrumental and collective. The instrumental case study affords the researcher the opportunity to focus on the “patients” concerns, illustrated via the case. *One flew over the cuckoo’s nest* can be viewed as an instrumental case study, which refers to an interest in a particular case with a view to the examination of an issue for insights.

### **3.3.4 Data Collection**

For the purpose of this study, qualitative data collection will involve showing the film to a panel of six qualified and experienced clinical psychologists who will view the film and answer the following three questions:

- (1) describe the dynamics of the psychiatric system as depicted in the film
- (2) identify and describe the impact of the system and or subsystems on the psychotherapeutic growth of the “patients” as depicted in the film
- (3) provide suggestions for the training of psychotherapists on the basis of the film and the present research.

### 3.3.5 Data analysis

All fieldwork culminates in the analysis and interpretation of the data. According to Mouton (2001), analysis involves “breaking up” the data into manageable themes, patterns and trends. A qualitative researcher interprets data by extracting meaning from and translating the data to facilitate understanding of the data.

The replies of the six psychologists in the present study will be analysed by means of the following five steps, as described by Pope, Ziebland and Mays (2000):

- (1) *Familiarisation*. This involves immersion in the raw data by studying the answers of the psychologists in order to list key ideas and recurrent themes.
- (2) *Identifying a thematic framework*. This entails identifying all the key issues, concepts and themes whereby the data can be examined and referenced. The end product of this stage is a detailed index of the data, which divides the data into manageable chunks for subsequent retrieval and exploration. Huberman and Miles (1994, as cited in Palys, 1997) suggest that preliminary description often involves noting patterns and themes observed in the setting as well as clustering similar people, events or processes together to begin forming categories as well as helping to see connections between objects, people and events.
- (3) *Indexing*. This is the process of applying the thematic framework to the data, using numerical or textual coding to identify specific pieces of data that correspond to differing themes. According to Coffey and Atkinson (1996),

coding links different segments in the data. The researcher brings these fragments of data together to create categories of data that are defined as having some common property or element. The coding thus links all these data fragments to a particular idea or concept.

- (4) *Charting*. This involves rearranging the data according to the appropriate part of the thematic framework to which they relate, and forming charts. Some researchers write accounts of the way in which the data have been interrogated, whereas others organise and display summarised and sorted data in diagrammatic form or figures (Ritchie & Lewis, 2003).
- (5) *Mapping and interpretation*. This is the final step in which the researcher puts together the analyses. This involves searching for patterns, associations, concepts and explanations in one's data. The process of mapping and interpretation is influenced by the original research objects as well as the themes that emerge from the data themselves.

### **3.3.6 Validity and reliability**

Reliability and validity are vital issues in all research, including qualitative research (Denzin & Lincoln, 2000).

#### **3.3.6.1. Reliability**

Reliability is the degree to which the results are repeatable. This applies both to the subjects' scores on measures (measurement reliability) and to the outcomes of the study as a whole. The researcher needs to demonstrate to the reader that the

outcomes obtained are reproducible and consistent. According to Whitley (2002) and Terre Blanche and Durrheim (1999), the researcher should consider the following:

- describing the approach and procedures for analyses
- justifying why these are appropriate in the context of the research
- clearly documenting the process of generating themes from the psychologists' notes (answers)
- referring to external evidence, including previous qualitative and quantitative studies, to test the conclusions drawn from one's analysis, as appropriate

### **3.3.6.2 *Validity***

Here the emphasis is on the validity of the interpretation. The ability of the findings to represent the "truth" may not be appropriate if one accept the existence and importance of multiple "truths". Validity will rather be judged by the extent to which an account seems to fairly and accurately represent the data collected (Terre Blanche & Durrheim, 1999).

Reflection is required on

- the impact of the research design and approach to the results as presented by the researcher

- the consistency of the researcher's findings: for example, has the analysis been conducted by more than one researcher, relating to the idea of interrater validity found in quantitative research?
- the extent to which the researcher has represented all relevant views, for example checking for "negative" or deviant cases to test the interpretations or the research
- adequate and systematic use of the original data (e.g. by using quotations) in the presentation of the analysis so that readers are convinced that the researchers' interpretations relate to the data gathered (Denzin & Lincoln, 2000; Terre Blanche & Durrheim, 1999).

### 3.3.7 Bias

According to Whitley (2002, p. 119): "Biased research produces invalid results: it leads to the inaccurate description of behavior and of relationships between variables, and to a poor understanding of behavior phenomena." The following strategies were used to avoid bias during the process of this qualitative study:

- Four independent clinical psychologists were used to answer three questions on *One flew over the cuckoo's nest*.
- Qualitative data analysis as described by Pope *et.al.* (2000) was conducted and the data analysis methods were applied consistently.

- No hypothesis was formulated that could have induced certain expectations in the present study. Instead, a neutral stance was adopted in analyzing the notes of the six clinical psychologists.
- The research results were reported explicitly and completely and thus open to inspection by the supervisor and external examiners to detect possible bias.
- There was an awareness that bias could exist at each stage of the process.
- The final research design was examined.

### **3.3.8 Ethical considerations**

Permission was requested from the MCREC (Medunsa Campus Research Ethics Committee). The researcher would inform the six clinical psychologists about the nature of the study, as well as their basic rights, including the right to privacy, to anonymity and confidentiality, to full disclosure about the research and not to be harmed in any manner.

## **3.4 METHOD**

### **3.4.1 Research procedure**

The research procedure, as elucidated under the research design, was followed.

### **3.4.2 Research sample**

Sampling was done as set out under the research design, by using the film *One flew over the cuckoo's nest* as a case study.

### **3.4.3 Data gathering**

It was not possible to enlist the services of six clinical psychologists trained at Medunsa Campus because of practical and time constraints. Only four clinical psychologists participated in the research. This was still considered to be adequate to ensure acceptable levels of reliability and validity.

### **3.4.4. Data analysis**

Data analysis was conducted as set out in the research design.

The results and discussion of the investigation are presented in the next chapter.

## **CHAPTER 4**

### **RESULTS AND DISCUSSION**

#### **4.1 INTRODUCTION**

This chapter deals with the results of the research and draws conclusions.

#### **4.2 RESEARCH RESULTS**

##### **4.2.1 QUALITATIVE ANALYSIS**

In accordance with the research design, four clinical psychologists were asked to do the following after watching the film, *One flew over the cuckoo's nest*:

- (1) Describe the interactional dynamics of the psychiatric system, as depicted in the film.
- (2) Identify and describe the impact of the systems and/or subsystems on the psychotherapeutic growth of “patients”, as depicted in the film.
- (3) Provide suggestions for the training of psychotherapists on the basis of the film and the present research.

The analysis of each of the clinicians is presented below (in tabular format). Corresponding themes have been identified and numbered. This is followed by an integration of the respective themes.

**Question 1: Describe the interactional dynamics of the psychiatric system as depicted in the film.**

**Themes identified by the four clinicians**

CLINICIAN 1	CLINICIAN 2	CLINICIAN 3	CLINICIAN 4
<p>Overall the psychiatric <u>system</u> as depicted in the film can be described as a <u>closed</u><sup>1</sup> and <u>rigid one</u><sup>2</sup>. The system <u>strictly enforces</u> its <u>existing norms</u><sup>3</sup> and does <u>not accept input</u><sup>4</sup> from outside. Thus <u>change and individuality</u><sup>5</sup> are <u>not tolerated</u>, and <u>conformation</u><sup>6</sup> is <u>rigidly and aggressively</u> enforced. This works decidedly <u>anti-therapeutic</u><sup>7</sup> and maintains the <u>psychological status quo</u><sup>8</sup>.</p>	<p>What follows is a brief interactional pattern analysis (IPA) of the psychiatric system, punctuating with the psychiatric staff-patient relationship. Given that RP McMurphy is a central figure in the movie, he will be used as an example of the psychiatric staff-patient interaction.</p> <p><i>Punctuating the Interaction from the side of the Psychiatric Staff</i></p> <p>a. <u>Context</u>:</p> <ul style="list-style-type: none"> <li>- A <u>38-year old</u> man, serving time for <u>statutory rape</u><sup>26</sup> (RP McMurphy) is <u>referred</u><sup>27</sup> by the prison to the <u>psychiatric hospital</u> for <u>psychiatric observation</u>.</li> </ul> <p>b. <u>Presenting Problem</u><sup>28</sup>:</p> <ul style="list-style-type: none"> <li>- The head of the hospital – a psychiatrist (Dr Spivey) – has to determine whether the patient is malingering (in order to avoid the discomforts of imprisonment) or is genuinely suffering from a psychological or psychiatric disorder.</li> </ul> <p>c. <u>Definition of the Relationship</u>:</p> <ul style="list-style-type: none"> <li>- The psychiatric <u>staff define</u> a <u>rigidly, complimentary relationship</u><sup>11</sup> with the <u>patient</u><sup>12</sup> (the staff take the lead and the patient follows – see the scene where RP McMurphy is</li> </ul>	<p>The members of the Psychiatric System (PS) <u>expressed</u><sup>3</sup> their <u>rules, regulations and needs very clearly</u> to the “patients”. They were thus able to state the procedures in a clear and <u>assertive manner</u>. Although information output was done effectively, the <u>PS functioned</u><sup>9</sup> as a <u>closed system</u><sup>1</sup>, allowing <u>no input</u><sup>4</sup> from the other subsystems. The system <u>functioned</u> in a very disciplined, <u>controlling</u> and rigid<sup>2</sup> manner, allowing for <u>no flexibility</u><sup>10</sup>. The <u>members of the PS defined the relationship in an excessive complimentary manner</u><sup>11</sup>, with the PS in the <u>one-up position</u> and the patient system in the <u>one-down position</u><sup>12</sup>. The members of the PS <u>lacked empathy</u><sup>13</sup> and <u>understanding</u> for the in-patient subsystem. The <u>effect of the controlling style</u><sup>14</sup> was that it <u>elicited rejection</u><sup>15</sup> <u>firstly</u> from McMurphy (considered initially as an individual with no mental disorders), and <u>ultimately</u> from the entire <u>in-patient</u><sup>16</sup> subsystem. The <u>PS functioned in a very linear manner</u><sup>17</sup> in terms of <u>identifying and solving problems</u>,</p>	<p>The psychiatric <u>system</u> is defined within the <u>medical model</u> which functions from a <u>linear inclination</u><sup>17</sup>. The <u>dynamics</u> within such a system can be defined as <u>rigid</u><sup>2</sup> and <u>complimentary</u><sup>11</sup> between <u>patient and staff member</u> resulting in a <u>fearful and closed system</u><sup>1</sup> which facilitates <u>conditional change</u><sup>5</sup>.</p>

	<p>ordered out of the nurse station by nurse Ratched), followed by an <u>escalating, symmetrical relationship</u> (staff and patient both attempt to take the lead or to take control – see the scene where RP McMurphy and [male] Nurse Itsu attack and assault each other), followed by an <u>extreme complimentary relationship</u><sup>11</sup> (the staff again leading – see the scene where RP McMurphy returns from the second and final round of shock therapy administered by the psychiatric staff).</p> <p>d. <u>Clarity of (Self)Presentation</u><sup>29</sup>:</p> <ul style="list-style-type: none"> <li>- Clarity of presentation in respect of the <u>problem</u> – trying to determine whether RP McMurphy is malingering or not – <u>is mixed</u> (although Dr Spivey presents very clearly to RP McMurphy, the rest of the staff do not).</li> <li>- Clarity of presentation in respect of the <u>self is low</u><sup>30</sup> (see the scene where Dr Spivey invites RP McMurphy to sit down and says “Let’s talk.” Dr Spivey is not clearly defining whether this is a social or therapeutic [that is, a doctor-patient]</li> </ul>	<p><u>defining rules</u><sup>3</sup> and <u>interactions</u>. The <u>in-patient system was often blamed</u><sup>18</sup> for problems, <u>without allowing for any feedback</u><sup>4</sup>. <u>No circular view</u><sup>19</sup> was thus obtained. Any attempts (by the other subsystems) to redefine the complimentary relationship was met with even <u>more rigidly controlling behavior</u><sup>20</sup> and <u>maneuvers</u><sup>12</sup> for the one-up position by the PS. The PS completely <u>ignored the context</u><sup>21</sup> within which behavior was taking place. One could <u>argue that the members of the PS attempted to show unconditional acceptance for the “patients”</u><sup>22</sup> (e.g. accepting that some “patients” are incapable of participating in certain events), but <u>without the necessary empathy and understanding, this unconditional acceptance</u> was in fact not unconditional but based on their own assumptions and beliefs and not on <u>objective observer</u><sup>23</sup> behavior and/or the “patients” <u>subjective experiences</u><sup>23</sup>.</p>	
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	<p>relationship).</p> <p>e. <u>Distance in the Relationship</u><sup>31</sup>:</p> <ul style="list-style-type: none"> <li>- The staff defines the distance in the relationship in an <u>extremely distant</u><sup>31</sup> way: This is maintained<sup>32</sup> by the staff displaying a <u>lack of empathy</u><sup>13</sup>; <u>openness</u>, <u>understanding</u>, and <u>vulnerability</u> (see Nurse Ratched's aloof, cold, unempathic and intellectual behavior as the group facilitator).</li> </ul> <p>f. <u>Empathy</u></p> <ul style="list-style-type: none"> <li>- The <u>staff does not exhibit empathy</u><sup>13</sup> to the patient (see nurse Ratched's unempathic handling of RP McMurphy's appeals to watch the game on TV).</li> <li>- The <u>staff</u><sup>33</sup> <u>does not receive empathy from the patient</u>.</li> </ul> <p>g. <u>Unconditional Positive Regard</u>:</p> <ul style="list-style-type: none"> <li>- The <u>staff does not give unconditional positive regard</u><sup>32</sup>. This is maintained by the staff's <u>judgmental</u><sup>31</sup> and <u>critical attitude</u><sup>18</sup> towards the patient (see [a] Nurse Ratched's judgment of RP McMurphy to Dr Spivey – in motivating to keep RP McMurphy in the hospital – as someone who has a problem or that there is something wrong with him and who is in need of treatment; and [b] Nurse Ratched's anger</li> </ul>		
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	<p>and extreme dismay and disappointment at RP McMurphy and the other “patients” party in the ward).</p> <ul style="list-style-type: none"> <li>- There is <u>no indication</u> of the staff receiving <u>unconditional positive regard</u>.</li> </ul> <p>h. <u>Congruence</u>:</p> <ul style="list-style-type: none"> <li>- The staff typically displays a <u>low level of congruence</u><sup>36</sup> (see Dr Spivey smiling in an apparently friendly way whilst asking RP McMurphy whether or not he was really mentally disturbed or just malingering).</li> </ul> <p>i. <u>Confirmation</u>:</p> <ul style="list-style-type: none"> <li>- The <u>staff does not confirm the patient</u><sup>6</sup>: This is again maintained by being <u>critical</u> and <u>judgmental</u> as well as <u>patronizing</u> and <u>condescending</u> to the patient (see the scene where RP McMurphy has to stand in a [school-like] queue along with the other “patients” to receive his medication).</li> </ul> <p>j. <u>Potential for Eliciting Acceptance/Rejection</u><sup>38</sup>:</p> <ul style="list-style-type: none"> <li>- The <u>staff</u> displays a <u>potential for eliciting strong rejection from the patient</u> by behaving in <u>rigid complimentary</u><sup>11</sup> <u>fashion</u>, <u>unempathic</u><sup>13</sup>, and <u>patronizing ways</u> (see RP McMurphy’s hatred for, and near</li> </ul>		
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	<p>strangling of, Nurse Ratched).</p> <p>k. <u>Expression of Needs</u><sup>39</sup>:</p> <ul style="list-style-type: none"> <li>- There is <u>no indication</u> of the staff <u>clearly, consistently, and congruently defining his/her own needs.</u></li> </ul> <p>l. <u>Linear/Circular Thinking</u><sup>17</sup>:</p> <ul style="list-style-type: none"> <li>- The staff does <u>not exhibit any awareness that their behavior or the context that they find themselves in,</u> contributes to the behavior of the patient and, in turn, their own behavior.</li> </ul> <p>m. <u>Meta-communication</u><sup>40</sup>:</p> <ul style="list-style-type: none"> <li>- The staff does <u>not exhibit meta-communication</u> (see, for example, that at no time does Nurse Ratched comment on, or give feedback on the communication within RP McMurphy's group).</li> </ul> <p>n. <u>Control</u>:</p> <ul style="list-style-type: none"> <li>- The staff demonstrates <u>extreme and rigid control</u><sup>20</sup> of the patient environment (see RP McMurphy's unsuccessful appeal to watch the game on TV).</li> </ul> <p>o. <u>Flexibility/Rigidity</u>:</p> <ul style="list-style-type: none"> <li>- The staff displays a high level of <u>rigidity</u><sup>2</sup> maintained by <u>unaccommodating behavior</u> (see example directly above).</li> </ul> <p>p. <u>Problem-solving Skills</u><sup>41</sup>:</p> <ul style="list-style-type: none"> <li>- The staff displays <u>poor,</u> if not anti-</li> </ul>		
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	<p>ethical (antithetical) problem-solving (see Nurse Ratched's damaging attempt to help McMurphy's group better understand the reason for Mr. Harding's wife supposedly having an affair: Here Nurse Ratched – apparently inadvertently – asked Mr. Harding two questions in succession on two different logical levels [“Maybe you should tell us why you suspect her;” and “Have you ever speculated, Mr. Harding, that perhaps you are impatient with your wife because she does not meet your mental requirements.”] which precipitated his psychotic reaction and subsequent disruption of the group).</p> <p>q. <u>Trauma</u><sup>42</sup>:</p> <ul style="list-style-type: none"> <li>- The <u>staff</u> is exposed to ongoing <u>trauma</u> (see RP McMurphy's near strangulation of Nurse Ratched and Billy Bibbit's suicide).</li> </ul> <p>r. <u>IPA in the Context of the Presenting Problem</u><sup>43</sup>:</p> <ul style="list-style-type: none"> <li>- Staff and patient are entrapped in a double-bind: If the individual accepts the <u>role as patient</u><sup>44</sup>, it confirms that he is mentally ill, and that he should be hospitalized further</li> </ul>		
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	<p>is indefinitely. If he resists the role as patient this confirms that he really is mentally ill and requires further hospitalization<sup>45</sup> until he does accept the role, and is therefore in need of further treatment<sup>46</sup> and hospitalization, and so on. The double-bind is maintained in part by the staff by their apparent lack of awareness of circular processes<sup>19</sup> and meta-communication (see for example Dr Spivey's request that RP McMurphy be honest with him as to whether he is malingering or not – if RP McMurphy says he is, the Dr Spivey is suspicious that he is really just trying to avoid hospitalization, whereas if RP McMurphy says he is not, the Dr Spivey is suspicious that he is avoiding further imprisonment). This <u>entrapment</u> is <u>further complicated</u> by the <u>staff's rigid</u><sup>2</sup>, <u>unempathic</u><sup>13</sup>, <u>distant and incongruent attempt</u> to maintain an extreme complimentary relationship<sup>11</sup>.</p> <p><i>Punctuating the Interaction from the side of RP McMurphy (Patient)</i></p> <p>a. <u>Context:</u></p> <ul style="list-style-type: none"> <li>- <u>Referred</u> to the psychiatric hospital by the prison for</li> </ul>		
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	<p>evaluation.</p> <p>b. <u>Presenting Problem:</u></p> <ul style="list-style-type: none"> <li>- RP McMurphy confirms to Dr. Spivey that he has a <u>tendency to fight</u> and <u>have sex excessively</u>. He also confirms that he <u>will cooperate</u> with Dr Spivey to determine whether he really is or is not malingering (see the scene where RP McMurphy says that he will cooperate with Dr Spivey “to get tot the bottom of RP McMurphy”).</li> </ul> <p>c. <u>Definition of the Relationship:</u></p> <ul style="list-style-type: none"> <li>- He initially defines the relationship in a <u>complimentary way</u><sup>11</sup>, <u>followed</u> by an <u>escalating symmetrical way</u>, and <u>again followed by a complimentary way</u> (see previous notes for psychiatric staff punctuation).</li> </ul> <p>d. <u>Clarity of (Self) Presentation:</u></p> <ul style="list-style-type: none"> <li>- His presentation of the problem is <u>generally clear</u> (see the scene where he acknowledges to Dr Spivey that he has a tendency to fight and have sex excessively – “I fight and fuck too much”).</li> </ul> <p>e. <u>Distance in the Relationship:</u></p> <ul style="list-style-type: none"> <li>- He <u>defines</u> the relationship with the psychiatric staff in a <u>distant way</u> by <u>not being congruent, open, and transparent</u> and by <u>making antisocial</u>.</li> </ul>		
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	<p><u>inappropriate and provocative gestures</u> (see the scene where Dr Spivey is “put out” by RP McMurphy’s [joking] insinuation that Dr Spivey may have included the chain in the total weigh-in of his prized fish).</p> <p>f. <u>Empathy</u>:</p> <ul style="list-style-type: none"> <li>- He <u>does not</u> give or receive empathy from the psychiatric staff.</li> </ul> <p>g. <u>Unconditional Positive Regard</u>:</p> <ul style="list-style-type: none"> <li>- He <u>does not give</u> or receive unconditional positive regard from the psychiatric staff.</li> </ul> <p>h. <u>Congruence</u>:</p> <ul style="list-style-type: none"> <li>- He presents with <u>low levels of congruence with the staff</u> (see the scene with Dr Spivey whereby he verbally communicates that he will cooperate in the formal observation, but he does so in a humorous manner).</li> </ul> <p>i. <u>Confirmation</u>:</p> <ul style="list-style-type: none"> <li>- Although he <u>tends to confirm the other “patients”</u>, he <u>does not confirm the psychiatric staff</u>, and <u>nor does he receive confirmation from the staff</u>.</li> </ul> <p>j. <u>Potential for Eliciting Acceptance/Rejection</u>:</p> <ul style="list-style-type: none"> <li>- He displays <u>high potential</u> for eliciting rejection which is maintained by his <u>incongruent, challenging, provocative, and</u></li> </ul>		
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	<p><u>antisocial behavior</u> (see the scene where he enters the nurses' station inappropriately and instructed to leave – nonverbal rebuke and rejection).</p> <p>k. <u>Expression of Needs:</u> - The expression of his needs was <u>generally clear and direct</u> (again see the scene where he expresses the need to watch TV).</p> <p>l. <u>Linear/Circular Thinking:</u> - He <u>exhibits linear thinking about the problem</u>, that is, at no stage does he display knowledge of the circular nature of staff-patient roles.</p> <p>m. <u>Meta-communication:</u> - He <u>does not exhibit meta-communication</u>.</p> <p>n. <u>Control:</u> - He exhibits a <u>high degree of control over his environment</u><sup>2</sup> (see the scene where he assists the “patients” to leave the hospital without permission and “charts” a boat).</p> <p>o. <u>Flexibility/Rigidity:</u> - He demonstrates a <u>high level of flexibility</u> maintained by <u>spontaneous and impulsive</u> behavior.</p> <p>p. <u>Problem-Solving Skills:</u> - He displays <u>reduced problem-solving skills</u> maintained by <u>impulsivity</u> and <u>poor judgment</u>.</p> <p>q. <u>Trauma:</u> - He has <u>been exposed to trauma</u> (see Billy Bibbit's</p>		
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	<p style="text-align: center;">suicide in the ward).</p> <p>r. <u>IPA in the Context of the Presenting Problem:</u></p> <ul style="list-style-type: none"> <li>- As noted earlier, he and the psychiatric staff are in a <u>double-bind that</u> – punctuated from his side – is maintained by his apparent lack of awareness of meta-communication and circular processes, especially in respect to their relationship context. This double-bind is further complicated by his income incongruent, manipulative, antisocial, and symmetrical behavior.</li> </ul>		
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#### ***4.2.1.1 Integration: Question 1***

##### *a. Themes identified by all **four** independent clinicians*

The dynamics of the system are consistently described as rigid<sup>2</sup>. Clinician 2 elaborates on this, observing the staff's extreme and rigid control<sup>2</sup> of the "patient" environment.

##### *b. Themes identified by **three** independent clinicians*

Three of the independent clinicians described the psychiatric system as a closed system<sup>1</sup>. According to the clinicians, change<sup>5</sup> and individuality are not tolerated.

The role players in this psychiatric system furthermore define the intersubsystem relationship as being excessively complementary<sup>11</sup>, maintaining the staff in a one-up and the "patients" in a one-down position.

The staff furthermore exhibit a linear inclination<sup>17</sup>. The staff show no awareness<sup>3</sup> of the impact of their behaviour and context on the nature of "patient" behaviour, leaving them in the dark on how their own behaviour reflects back to them through that of the "patients".

##### *c. Themes identified by **two** independent clinicians*

The system strictly enforces its existing norms<sup>3</sup> and does not allow input<sup>4</sup> from other subsystems.

The “patients” are not confirmed<sup>6</sup> by the staff. This is evident in the staff’s criticism, judgment and their patronising and condescending behaviour towards the “patients”. Clinician 1 explained this as follows: “confirmation<sup>6</sup> is rigidly and aggressively enforced”.

A rigid, complementary “patient-relationship” is prescribed by the staff, placing staff members<sup>12</sup> as leaders and “patients” as followers in the setting. Clinician 3 elaborated on this by stating that the “patient”<sup>12</sup> system is in the extreme one-down position and the psychiatric system in the one-up position.

The staff of the psychiatric system lacked empathy<sup>13</sup> and understanding for the in-patient subsystem. The staff often blamed<sup>18</sup> the “patients” for problems in the psychiatric setting. Clinician 2 elaborates further by stating that the staff maintained a critical attitude<sup>18</sup> towards the “patients”.

The “patient” environment was rigidly controlled<sup>20</sup> by the staff, supporting the assumption of a closed system. The staff seemed to lack awareness of circular processes<sup>19</sup> and meta-communication. This lack of awareness is underscored by the staff’s ignorance of the effect of their behaviour and context on that of the “patients”.

#### **4.2.1.2 Conclusion**

The interactional dynamics of the psychiatric system as depicted in the film can be described as rigid. The staff demonstrated rigid control over the “patients” and change and individuality were not tolerated in the system. Ignorance of the fact that

their behaviour contribute to that of the “patients”, supports the idea that the staff had an apparent lack of awareness of circular processes in the psychiatric context.

The psychiatric system could also be defined as a closed system. Its existing norms were enforced on the “patients”, allowing no input from the “patient” subsystem. Furthermore, the “patients” were not confirmed by the staff, in the sense that the staff were critical, judgmental, patronising and condescending. A lack of empathy for and understanding of the “patient”, as well as a critical and blaming attitude, characterised the general conduct of the staff.

The relationship between the psychiatric staff and the “patients” can be defined as complementary, with the “patient” in the one-down position and the staff in the one-up position.

**Question 2: Identify and describe the impact of the systems and or sub-systems on the psychotherapeutic growth of “patients” as depicted in the film.**

**Themes identified by the four clinicians**

CLINICIAN 1	CLINICIAN 2	CLINICIAN 3	CLINICIAN 4
<p>a. <u>Context</u> A <u>psychiatric hospital</u><sup>1</sup> in which there are <u>two sub-systems</u><sup>2</sup>, namely, <u>staff</u> and <u>“patients”</u> who are defined as mentally ill and in <u>need of treatment</u>. This <u>immobilizes</u> the “patients” and renders them <u>helpless and perpetually “ill”</u>.</p> <p>b. <u>Definition of relationships</u> The relevant relationship is between the individual <u>“patients”</u><sup>4</sup> and the <u>treatment staff</u>. This relationship is <u>defined</u> as <u>complementary</u><sup>5</sup> with the “patients” in the <u>one-down</u> position. Any <u>maneuver</u> by a “patient” to <u>redefine</u> this relationship is <u>vehemently countered and blocked</u><sup>6</sup>, even <u>violently and aggressively</u> if necessary. “patients” sometimes <u>escalate</u><sup>7</sup> their attempt to <u>redefine this relationship</u> but the <u>staff sub-system always out-maneuvers</u> them. This fosters <u>pathological dependency</u><sup>8</sup>.</p> <p>c. <u>Distance</u> There is <u>extreme distance</u><sup>9</sup> between staff-sub-system</p>	<p>The <u>underlying philosophy</u> of (Carl Rogers’)<sup>31</sup> person centered therapy is that in order for the individual to undergo growth within the therapeutic relationship there needs to be sufficiently <u>high levels of congruence</u>, <u>unconditional positive regard</u>, and <u>empathy</u> on the part of the therapist. From the IPA above, it appears that the <u>psychiatric staff</u> displays <u>low</u><sup>14</sup> levels of <u>congruence</u><sup>17</sup>, <u>unconditional positive regard</u><sup>16</sup>, and <u>empathy</u><sup>14</sup>. In addition to this, the staff display: a) a <u>rigid, complimentary relationship</u><sup>5</sup>, b) <u>poor clarity of presentation</u><sup>29</sup>, c) <u>high distance</u><sup>9</sup>, d) a <u>lack of confirmation towards “patients”</u><sup>17</sup>, e) a <u>high potential for eliciting rejection</u><sup>32</sup> from “patients”, f) a <u>limited expression of needs</u><sup>20</sup>, g) <u>excessive and rigid control</u><sup>23</sup>, h) <u>high rigidity</u><sup>33</sup>, and i) <u>limited or ineffective problem-solving</u><sup>24</sup>. From this it can be concluded that in the film the psychiatric staff have an <u>anti-therapeutic effect on the “patients”</u><sup>12</sup> (see, for example, the scenes where Billy Bibbit commits suicide and where Chief Bromden murders RP McMurphy in the humane attempt to rescue RP McMurphy from an extremely hostile and anti-therapeutic</p>	<p>The psychiatric system (PS) inhibited growth with its <u>controlling manner</u><sup>20</sup>. The <u>member</u> of the PS worked with <u>assumptions</u>, <u>lack of understanding</u> and <u>lack of empathy</u><sup>14</sup> for “patients” and often went as far as “thinking for the “patients””. At times they <u>attempted to display positive regard</u><sup>6</sup> and <u>unconditional acceptance</u> of “patients” (often allowing them to behave in their “characteristic manners”). These <u>attempts at unconditional acceptance and positive regard</u><sup>6</sup> were however unsuccessful as these attempts were <u>executed without listening effectively</u><sup>38</sup>, <u>accepting input and feedback</u><sup>39</sup>, and <u>displaying a lack of empathy</u> for the “patients”. The PS <u>rigidly ignored inputs</u><sup>39</sup> and <u>lacked the ability to listen to “patients”</u><sup>40</sup>, sometimes completely <u>overriding input</u><sup>39</sup> (e.g. during the voting process). This resulted in a complete <u>lack of understanding for the needs</u><sup>20</sup>, feelings and emotions of the “patients”, ultimately leading to the <u>frustration</u> of these needs/feelings/emotions. This <u>style is unlikely to encourage growth</u><sup>41</sup> and recovery in “patients”. It could be argued that this interactional <u>style</u> might even <u>contribute to a further deterioration of mental and psychological well-being</u><sup>42</sup>. The positive impact of this style remains limited as long as it functions in a <u>closed</u></p>	<p><u>Psychotherapeutic growth</u><sup>41</sup> can effectively take place if the system providing the treatment is <u>flexible</u> – thus <u>accepting the patient empathically and congruently</u><sup>14</sup>.</p> <p>The psychiatric system in a similar clinic context <u>does not allow for psychotherapeutic flexibility</u><sup>33</sup> and ironically does <u>not allow for individual growth</u><sup>41</sup>, unless the <u>patient strictly adheres to the norms of the system</u><sup>12</sup>, which creates a <u>paradoxical effect</u>.</p>

<p>and “patient” sub-system.</p> <p><u>Vulnerability</u><sup>10</sup> on the part of “patients” is <u>exploited to maintain control and the status quo</u>. The staff remains <u>untouchable</u><sup>11</sup>. Various <u>anti-therapeutic norms</u><sup>12</sup> are maintained that result in <u>isolating individual “patients”</u><sup>13</sup> and <u>prevent effective sub-grouping or supportive relationships</u>. This is anti-therapeutic and <u>promotes psychopathology</u>.</p> <p>d. <u>Empathy</u> In the relationship with staff and “patient” empathy is practically <u>non-existent</u><sup>14</sup> and <u>active rejection</u><sup>15</sup> and <u>disregard</u> of “patients”<sup>16</sup> <u>subjective experience</u> are evident. This is <u>anti-therapeutic</u><sup>12</sup>.</p> <p>e. <u>Unconditional Positive Regard</u><sup>16</sup> The psychiatric system, as depicted in the film, is characterized by <u>judgmentally</u><sup>16</sup> and <u>moralistic criticism</u> which is strongly <u>anti-therapeutic</u><sup>12</sup>.</p> <p>f. <u>Congruence</u><sup>17</sup> The communication between staff and “patients” is characterized by <u>various degrees of incongruence</u><sup>17</sup>. This <u>confuses and immobilizes and promotes psychopathology</u><sup>8</sup>.</p> <p>g. <u>Confirmation</u></p>	<p>environment).</p> <p>Furthermore, the way the <u>staff/doctor-patient roles</u><sup>34</sup> are <u>maintained</u> serves to <u>further limit the therapeutic growth of the “patients”</u><sup>12</sup>. A good example of this is when the group, under TP McMurphy’s leadership “charters” a boat. During this scene RP McMurphy introduces the group as staff members from the hospital and for a moment the individual roles are <u>redefined from “patient” to “doctor”</u> and this is associated with a <u>significant and positive change in their behavior</u>.</p> <p>The <u>limited and ineffective (group) facilitation skills</u><sup>35</sup> of nurse Ratched serve to <u>further reinforce the anti-therapeutic environment</u><sup>12</sup> of the hospital. Consider, for example, the following:</p> <p>a) She <u>changed logical levels</u><sup>36</sup> when communicating with Mr. Harding; the effect of which was so severe that it precipitated his psychotic reaction and breakdown of the group.</p> <p>b) She <u>spoke in an indirect way</u><sup>29</sup>, maintained by her vague and obscure references to information about individuals of the group.</p>	<p><u>system</u><sup>43</sup>. This type of <u>rigid control</u><sup>20</sup> is likely to <u>devastate any attempts at growth</u><sup>41</sup> and improvement as was ultimately witnessed in the movie, especially with regards to patient McMurphy. The PS became <u>more controlling</u><sup>20</sup> and <u>rigid</u> in the face of any symmetrical maneuvers from the “patients”. Without any input from the other systems the PS <u>defined all behavior as abnormal behavior</u><sup>44</sup> and failed to see potential and even “normality”. In doing this they did not only <u>inhibit growth</u><sup>41</sup> but in patient McMurphy’s case even attempted to <u>facilitate and eventually create mental illness</u> and destroy all possibility of rehabilitation and recovery.</p> <p>The <u>subsystem</u> consisting of <u>eight “lucid” “patients”</u><sup>45</sup>, under the <u>influence and leadership of McMurphy showed growth and improvement</u>. McMurphy <u>encouraged learning, lateral thinking and stimulation</u><sup>40</sup>. He initially took a <u>strong dominant leadership role</u>, and thus defined the relationship in a <u>complimentary manner</u> with him in the one-up role, but as the other “patients” showed growth and improvement he <u>adjusted his style to a more parallel style</u>. Through <u>teaching, exhibiting trust and expressing a belief in the abilities of others</u>; displaying an <u>adequate amount of empathy</u> towards others, and exhibiting a <u>flexible and circular approach</u>, he <u>enabled the “patients” (“patients” subsystem) to</u></p>	
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<p>“patients” are <u>not confirmed</u><sup>18</sup> in respect of healthy individuality, creativity, problem solving and independent judgment but only in respect of <u>conformation</u><sup>19</sup> and compliance. This fosters <u>pathological dependency</u><sup>8</sup> and <u>incompetency</u>.</p> <p><i>h. Expression of needs</i> This is actively <u>discouraged</u><sup>20</sup> and <u>blocked</u> and “patients” become <u>alienated in respect of their own needs</u>. This is a <u>pathological</u><sup>8</sup> condition.</p> <p><i>i. Linear vs. Circular Approach</i> The <u>circular patterns</u><sup>21</sup> of interaction between members of staff and “patients” are <u>not acknowledged</u> and “patients” are <u>linearly labeled</u> as <u>ill</u> and <u>malfunctioning</u>, which maintains <u>pathology</u><sup>8</sup>.</p> <p><i>j. Locus of control</i> Various norms as outlined above combine to maintain an <u>external locus of control</u><sup>23</sup> in respect of the “patients” and an internal locus of control is actively <u>blocked</u> and <u>prevented</u> (even by means of lobotomy).</p> <p><i>k. Problem solving</i> Various norms as set out above combine to actively <u>block and prevent</u> “patients”<sup>24</sup> to</p>	<p>Such indirect communication on the part of the facilitator can precipitate psychosis – disorientation to time, person or place.</p> <p>c) She displays a <u>lack of congruence and transparency as a facilitator</u><sup>17</sup>.</p> <p>d) She <u>communicates in a patronizing and condescending way</u><sup>29</sup> which further maintains the disempowered position of the “patients”.</p> <p>e) Her <u>use of manipulation and unclear communication of needs</u><sup>29</sup> in an attempt to steer the group (see the scene where she says to Billy Bibbit that she wants to write in her book/journal for today’s session that he spoke first or took the lead).</p> <p>f) Her <u>use of punitive and threatening communication to maintain a complimentary relationship with the “patients”</u><sup>29</sup> (see the scene where she threatens Billy Bibbit that she</p>	<p><u>grow</u><sup>37</sup> and <u>improve</u> to the <u>extent that they were becoming empowered enough to start challenging rules and procedures of the PS</u>.</p>	
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<p>develop any problem-solving skills, thus maintaining a <u>pathological dependency</u><sup>8</sup> and inadequacy.</p> <p><i>l. <u>Meta-communication</u></i>  A <u>double standard</u><sup>25</sup> exists in respect of meta-communication: Members of <u>staff meta-communicate</u><sup>26</sup> with reference to “patients” and their behavior. “patients” on the other hand <u>are not allowed to meta-communicate</u><sup>27</sup>. This <u>results</u> at times in <u>escalation</u><sup>28</sup> on the part of the “patients” which are violently and aggressively counteracted by the staff.</p> <p><i>m. <u>Clarity of self-presentation</u></i><sup>29</sup>  Punctuated from the <u>staff</u>, self-presentation is often <u>unclear</u> and <u>ambiguous</u> with a <u>confusing and immobilizing impact on “patients”</u>. Punctuated from the “patients”<sup>30</sup> communication is also <u>mostly unclear</u> and <u>ambiguous</u> as a result of various restrictive forms referred to above, thus <u>encapsulating “patients” in a pathological role</u><sup>8</sup>.</p>	<p>will tell his mother about his sexual encounter, which precipitates his suicide).</p> <p>Given that the “patients” have to sustain themselves in a <u>hostile, anti-therapeutic environment</u><sup>13</sup>, the <u>patient subsystem itself appears to offer the potential for significant support and therapeutic growth and development</u><sup>37</sup> (see the scenes where, with help from RP McMurphy, Billy Bibbit has a (emotional) corrective sexual encounter and Chief Bromden shows that he is not deaf or mute and retains the capacity to hear, understand and talk meaningfully.</p>		
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#### **4.2.1.3. Integration: Question 2**

##### *a. Themes identified by all **four** independent clinicians*

The relationship between the staff and “patient” population exhibited either very little, or no empathy<sup>14</sup> at all.

##### *b. Themes identified by **three** independent clinicians*

The conduct of the staff, as depicted in the film, was considered to be antitherapeutic<sup>12</sup>, thus promoting psychopathology<sup>8</sup> in the “patient” population.

The staff’s inability to listen to the “patients”, reluctance to embrace feedback and a lack of empathy for the “patients”, leads one to conclude that they exhibited low levels of unconditional positive regard<sup>16</sup> for the “patients” in their care.

The attitude of the staff was clearly one of disregard for the needs<sup>20</sup>, feelings and emotions of the “patients”. This inability to understand the needs of the “patients”, or the active discouragement and blocking of its expression, led to the “patients” being alienated from the recognition of their needs<sup>20</sup>.

Any possible growth or development that could have taken place in the psychiatric system was inhibited by the staff’s controlling manner<sup>23</sup>.

##### *c. Themes identified by **two** independent clinicians*

The staff-“patient” relationship exhibited a complementary style<sup>5</sup>, placing the staff in a one-up position, and the “patients” in a one-down position.

High levels of congruence<sup>17</sup> are considered to facilitate growth in the therapeutic relationship. However, in this setting, the communication between the staff and “patients” was characterised by varying degrees of incongruence<sup>17</sup>.

In the psychiatric system, there is a noticeable, if not extreme distance<sup>9</sup> between the subsystems of the staff and “patients”.

The staff punctuated an unclear and ambiguous self- presentation<sup>29</sup> of the “patients”, leaving the latter confused and immobilized. The psychiatric system displayed and maintained various anti-therapeutic norms<sup>12</sup>.

The “patients” were not confirmed<sup>18</sup> in respect of healthy individuality, creativity, problem solving and independent judgment. Instead of facilitating the development of problem- solving skills<sup>24</sup>, the “patients” were actively prevented from acquiring or expanding such skills.

The rigidity<sup>33</sup> of the staff served to maintain the prevention of the psychotherapeutic flexibility<sup>33</sup> being expressed in the psychiatric system.

The “patient” subsystem<sup>37</sup> offered an immense potential for significant support and psychotherapeutic growth and development. This subsystem was portrayed by clinician 3 as eight “lucid “patients””, under the influence of McMurphy, who exhibited substantial growth and improvement.

The style of the staff served to impair, instead of encourage growth<sup>41</sup> and recovery in the “patients”.

#### ***4.2.1.4 Conclusion***

It is necessary to identify and describe the impact of the system and subsystems on the psychotherapeutic growth of “patients” as depicted in the film. The person-centered therapy of Carl Rogers is founded on the philosophy that individual growth stems from high levels of congruence, unconditional positive regard and empathy in the therapeutic relationship, especially on the part of the therapist or psychiatric staff members. The four clinicians consulted all agreed the psychiatric system as discussed lacked three of the elements required for “patient” growth, failing to exhibit congruence, unconditional positive regard or empathy in this system.

In addition to the above- mentioned factors, the staff subsystem also continued to be ineffectual in matters such as listening to the “patients” and understanding their requirements, and they used anti-therapeutic norms that actually worsened psychopathology in the “patient” subsystem.

There was no confirmation of the ““patients”” creativity, problem- solving skills and individual judgment. The unclear presentation of the psychiatric staff only served to confuse the “patients”, thus immobilizing them and leaving them unable to change their status quo. The psychiatric staff denied psychotherapeutic flexibility by means of rigid control. A complementary staff-“patient” relationship was evident throughout the film - one that placed the “patients” in a one-down position. The relationship between the staff and “patient” subsystems was portrayed as extremely distant, leaving little scope for improving the situation.

**Question 3: Provide suggestions for the training of psychotherapists by means of the film and the present research.**

**Themes identified by the four clinicians**

CLINICIAN 1	CLINICIAN 2	CLINICIAN 3	CLINICIAN 4
<p>Viewing the DVD with discussion of the above mentioned variables should provide an <u>excellent training experience</u><sup>1</sup> for students.</p>	<p>The film is a potentially rich and valuable aid in the <u>training of psychotherapists</u><sup>1</sup>, namely it can be used for the following purposes:</p> <ul style="list-style-type: none"> <li>• To <u>introduce students</u> to the <u>possible limitations and weaknesses</u><sup>8</sup> associated with <u>psychiatric hospitals</u>.</li> <li>• To <u>sensitize students</u> about the <u>clients'/patient's context</u><sup>9</sup> within the hospital system.</li> <li>• To help students better <u>understand how it's not only the patient</u>, but also the <u>doctors/staff</u> who can be <u>entrapped in anti-therapeutic roles</u><sup>10</sup>.</li> <li>• To prepare students for the <u>challenges and difficulties</u><sup>11</sup> they are likely to <u>encounter</u> when they assume their therapeutic role within such a system.</li> <li>• To teach students about the <u>finer nuances of group facilitation</u><sup>12</sup> and about the <u>dangers of untrained facilitation</u><sup>13</sup>.</li> <li>• As a tool, to <u>train students to observe more accurately</u><sup>14</sup>; <u>paying close attention to verbal and nonverbal</u></li> </ul>	<p>The movie can be <u>effectively utilized</u><sup>1</sup> as a training tool. After a thorough knowledge and understanding of systems and Interactional Pattern Analysis are obtained, the movie can be used as an exercise in <u>analyzing the dynamics of the systems and subsystems</u><sup>2</sup>.</p> <ul style="list-style-type: none"> <li>• <u>Each patient's Interactional Behavioral Patterns</u><sup>3</sup> can be <u>analyzed</u> and described and the <u>logical link</u><sup>4</sup> between their <u>presenting complaints</u> and the <u>Interactional Behavioral Patterns</u> can be described.</li> <li>• Furthermore the students can be requested to <u>describe the dynamics and impact</u><sup>5</sup> of the <u>various subsystems on other subsystems</u> has on the effect of growth (9as was done in this study).</li> <li>• <u>Suggestions</u> can be made by <u>students regarding possible changes</u><sup>6</sup> <u>to the Psychiatric Subsystem</u> in order to <u>encourage</u><sup>7</sup> and facilitate psychological well-being and growth.</li> </ul>	<p>First and foremost the <u>effect of such a closed system can be demonstrated</u><sup>2</sup> and <u>experienced</u> – as subjective awareness creates a frame of reference.</p> <p>The film can also be used to <u>identify communicative entrapping statements and effects</u><sup>18</sup> which will also assist the trainee to guard against falling into a similar pattern in future.</p>

	<p><u>communication/behavior<sup>15</sup>, context<sup>16</sup> and logical levels of communication associated with problem formation and resolution<sup>17</sup>.</u></p> <ul style="list-style-type: none"> <li>• To teach students (or interns) about <u>interactional pattern analysis (IPA)<sup>3</sup></u> and its specific features.</li> <li>• To demonstrate to students the <u>variables necessary for psychotherapeutic growth<sup>7</sup></u> and how these <u>variables can be systematically identified and corrected<sup>6</sup>.</u></li> <li>• To alert students to the <u>difficulties associated with different contexts<sup>18</sup></u>, such as forensic and medical contexts – as is often encountered in medico-legal work.</li> </ul>		
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#### 4.2.1.5 Integration: Question 3

##### a. Themes identified by all **four** independent clinicians

There were no correlating themes identified by all *four* independent clinicians with regard to suggestions for the training of psychotherapists.

*b. Themes identified by **three** independent clinicians*

Three of the clinicians concurred that this film would be a valuable<sup>1</sup> means of training for clinicians.

*c. Themes identified by **two** independent clinicians*

The film *One flew over the cuckoo's nest*, provides a valuable source of patient-case studies for students to apply the Interactional Behavioral Pattern<sup>3</sup>. Furthermore, the students could be requested to describe<sup>6</sup> the dynamics and impact of the various subsystems on other subsystems. Clinician 2 expanded on this theme by stating that these variables<sup>6</sup> can be systematically identified and corrected. In this regard, clinician 3 mentioned possible<sup>6</sup> changes to the psychiatric system. Students could make suggestions about variables<sup>7</sup> that are required for psychotherapeutic growth. The film could also be used to identify<sup>17</sup> problems in the communication process and the effects thereof.

**4.2.1.6. Conclusion**

*One flew over the cuckoo's nest* has the potential to be a source that enhances the training of psychotherapists, providing them with a variety of tools and skills for conduct in the psychiatric and therapeutic setting. These tools and skills include the use of Interactional Behavioral Analysis, the description and observation of subsystem dynamics and the identification of changeable variables in the psychiatric setting and entrapping communications.

### 4.3 OVERALL DISCUSSION AND CONCLUSION

The objectives of the research study were as follows:

- Describe the interactional dynamics of the psychiatric system as depicted in the film
- Identify and describe the impact of the systems and or subsystems on the psychotherapeutic growth of “patients” as depicted in the film
- Provide suggestions for the training of psychotherapists on the basis of the film and the present research.

The interactional dynamics of the psychiatric system as depicted in the film can be described as rigid. The staff demonstrated rigid control over the “patients” and change and individuality were not tolerated in the system. Ignorance of the fact that their behaviour contributed to that of the “patients” supports the idea that the staff had an apparent lack of awareness of circular processes in the psychiatric context.

The psychiatric system could also be defined as a closed system. Its existing norms were enforced on the “patients”, allowing no input from the “patient” subsystem. Furthermore, the staff failed to confirm the “patients”, which was evident in the staff being critical, judgmental, patronizing and condescending.

The relationship between the psychiatric staff and the “patients” could be described as complementary, with the “patient” in the one-down position and the staff in the one-up position. The relationship between the staff and “patient” subsystems was portrayed as extremely distant, leaving little chance for improving the situation.

The person-centered therapy of Carl Rogers is founded on the philosophy that individual growth stems from high levels of congruence, unconditional positive regard and empathy in the therapeutic relationship, especially the part of the therapist or psychiatric staff members. The four clinicians who were consulted, concurred that the psychiatric system discussed was lacking in all three areas required for “patient” growth, failing to exhibit congruence, unconditional positive regard or empathy in this system.

In addition to the above factors, the staff subsystem also continued to be ineffective in matters such as listening to the “patients” and understanding their requirements. The staff also used anti-therapeutic norms that only worsened psychopathology in the “patient” subsystem.

There was no confirmation of the “patients’” creativity, problem-solving skills and individual judgment. The unclear presentation of the psychiatric staff only served to confuse the “patients”, thus immobilising them and leaving them unable to change their status quo.

One could argue that the interactional style of the psychiatric staff contributed to the further deterioration of the mental and psychological well-being of the “patients”, thus inhibiting their psychological growth and promoting psychopathology. Ironically, the “patient” subsystem itself, appeared to offer the potential for significant support and therapeutic growth and development.

*One flew over the cuckoo's nest* has the potential to enhance the training of psychotherapists, providing them with a variety of tools and skills to apply in the psychiatric and therapeutic setting. These tools and skills include the use of the interactional behavioral analysis, describing and observing the subsystem dynamics and identifying changeable variables in the psychiatric setting and entrapping communications.

It is clear that the objectives of the research study were met. The four clinicians gave valuable input, which could be used in the training of psychotherapists. The objectives sensitised the researcher, and hopefully, other current and future psychotherapists, to the possible inhibiting effects of a psychiatric institution on the psychotherapeutic growth of a "patient". The suggestions made by the clinicians and trainee psychotherapists could be incorporated into the psychiatric system to assist the psychotherapeutic growth of the "patients".

Further research is necessary and the above proposals will hopefully support further research on the psychiatric system and its effects on the "patients".

## **CHAPTER 5**

### **CONCLUSION**

In recent years there has been an increasing trend towards hospital treatment for psychiatric problems. This shift has proposed many advantages for the “patients”, who are supposed to benefit from the collected expertise present in the hospital (Weinman, 1987).

However, even though the psychiatric system was created to assist and improve the quality of life of the mental “patient”, it is possible that the paradigm of operation of the psychiatric system may hamper or impair the “patient’s” psychotherapeutic growth.

It is therefore necessary to evaluate the psychiatric institution with a view to carefully examining the impact of this system as a whole on the mental well-being of its “patients”. However, undertaking this kind of evaluation is by no means easy or straight- forward.

The institutionalisation of “mad people” in psychiatric institutions has placed the professional (psychiatrist) in a legitimate expert position of authority when concerned with the “patient”, leaving the latter out of the decision-making process. In this setting, the “patient” loses his or her identity to simply become a diseased individual – a presentation of a mental disorder. (Playle & Keeley, 1989). This relationship between the psychiatrist and “patient” in the psychiatric context is complementary,

placing the former in a leader-role and the latter in a follower-role (Carter, 2003). However, this kind of relationship not only represents the psychiatrist-“patient” roles, but also accurately portrays the relationships between staff members and “patients”, indicating a huge and unchangeable divide in the dynamics of the psychiatric system. These dynamic leave the “patients” outside when it comes to decision-making, merely allowing them to be recipients of the decisions made.

It is in this context that the film *One flew over the cuckoo's nest* was identified as a possible medium to tentatively investigate the nature and effect of a psychiatric system as portrayed through this particular film. For the purpose of this study, the psychiatric system as depicted in the film was analysed in order to gain insight into the inner-workings of such a system and its effects on the in-”patients” and their psychotherapeutic growth. Four clinicians were asked to view the film, describe the dynamics of the psychiatric system and its subsystems, its effects on the psychotherapeutic growth of the inmates, and make suggestions on how the film could be used in the training of psychotherapists in the psychiatric system.

The conclusions drawn from this study are disturbing. The film depicts the psychiatric system as rigid, leaving “patients” with little room to express their individuality. The effect of the staff-members’ behaviour on the “patient’s” psychotherapeutic growth, highlights the staff’s ignorance and lack of meta-cognition of their individual responsibility, contributing to the psychopathology of not only the “patients”, but also the system as a whole. The circularity of the processes

experienced in the hospital, is seemingly lost on the staff, verifying their lack of awareness of their effect on the system.

The psychiatric system is considered to be a closed system - one that does not allow input from the “patient-subsystem”, but instead enforces existing norms onto it. The relationship between the psychiatric staff and the “patients” in the film can be described as complementary, with the “patient” in the one-down position and the staff in the one-up position. The relationship between the staff- and “patient” sub-systems is portrayed as somewhat distant, leaving little chance of improving the situation.

In addition to the above mentioned factors, the staff sub-system, as depicted in the film, also continues to fall short on matters such as listening to the “patients” and understanding their requirements, as well as, the presence of anti-therapeutic norms, such as inhibiting the expression of individuality, being incongruent and disempowering the “patient”.

The findings of this study seem to indicate that the interactional style of the psychiatric staff, as portrayed in the film, serves to contribute to the deterioration of the mental and psychological well-being of the “patients”, thus inhibiting their psychological growth and promoting psychopathology.

Several studies underscore the possibility that the film’s representation of a psychiatric institution, may actually be a relatively accurate portrayal of a typical psychiatric institution. Carter (2003), for example, contends that the “patient’s” compliance with the hospital routine becomes a serious norm in the mental

institution. The “patients” have to obey the staff’s instructions, which entails adhering to a specific treatment. If a “patient” ‘steps out’ of line, he or she will be brought back by the use of either medication, seclusion or punishment. Thus, in order to avoid “punishment” the “patients” have to remain in their “sick” roles and behave according to their diagnostic label.

Carter (2003) goes on to say that their incapacity to adopt a more flexible approach has led to psychiatric institutions becoming associated with chronic “patient” populations with a poor prognosis. Walton (2000) describes psychiatric hospitals as having an extremely traditional medical approach, that is physically focused and often judgmental.

According to Walton (2000) and Weinman (1987), the negative effects of mental institutions on in-”patients” can be summarised as follows: loss of control, apathy, resignation, dependence, alienation and depersonalisation, demotivation resulting from lack of choice, withdrawal because of boredom, loss of confidence and self-esteem and stigma and disempowerment.

A possible solution to this seemingly unhealthy state of affairs may be found in a paradigm shift away from the traditional medical/psychiatric approach to a systems based epistemology. This paradigm shift would result in viewing the psychiatric institution as a hierarchy of interrelated subsystems-in-interaction and open up possibilities for redefining the various roles within the larger system, such as

“patient-patient” relationships and “patient”-staff relationships. Hence further research in this direction seems strongly indicated and recommended.

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