DEVELOPMENT OF THE PSYCHIATRIC UNIT OF THE JOHANNESBURG HOSPITAL AND THE ROLE OF THE CLINICAL PSYCHOLOGIST

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DEVELOPMENT OF THE PSYCHIATRIC UNIT

A psychiatric outpatient clinic was started at the Johannesburg Hospital in 1932 attended by part-time psychiatrists. A full-time consultant psychiatrist was appointed to the staff in November 1950 to ensure that psychiatric consultation was available at all times, but there were no psychiatric beds as yet. In January 1959 a Chair of Psychological Medicine was established at the University of the Witwatersrand and Prof. L. A. Hurst was appointed to it. He was at the same time appointed Chief Psychiatrist of the Johannesburg Hospital.

It was then decided to establish an inpatient psychiatric unit at the Johannesburg Hospital which is the teaching hospital of the University. Conferences took place with the Medical Superintendent of the hospital and twelve medical beds were converted to psychiatric ones in one of the wards. A senior houseman was appointed in February 1959.

However, the attitudes of the staff to psychiatric services were varied, and, particularly on the part of the nursing staff, much resistance had to be overcome. Conferences were held to orientate the nursing staff towards

an understanding of the 'open-door' treatment of the mentally ill. Methods of treatment were discussed and the incorrectness of physical methods of restraint was pointed out. Much time was devoted to explaining that patients who were treated in these wards were not certified and had a right to abscond in the same way as other patients had a right to refuse hospital treatment. The problem of patients threatening suicide was—and still is—a cause for concern. To obviate this danger as far as possible it was decided that the location of the Psychiatric Unit should be on the ground floor.

In July 1960 a whole ward was converted into a psychiatric one containing 32 beds—16 male and 16 female.

In November of the same year the ward was split up and the male patients were moved to a separate part of the hospital. Work was continually increasing for the unit and, after the departure of the houseman, posts for 3 psychiatric registrars were created in October 1960. Greater contact took place between the psychiatric staff and other professions of the unit, and a social worker* was seconded to the unit by the Social Welfare Department. One month later an occupational therapist was appointed to duty in the psychiatric wards. She also assisted in a relaxation programme, but it appeared shortly afterwards that patients would benefit more from occupational therapy in a central department where they could mix socially with other patients. Specialized services, such as physiotherapy, were requested as needed and at one time a physiotherapist was regularly involved in 'gym' activities for the men. A clinical psychologist (L.M.C.L.) who had been working part-time since December 1960, began working in a full-time capacity in February 1961.

Nursing staff were assigned to the unit during their training and the average number of nurses per ward was 5, including the sister and any other trained staff member. The total number of nursing staff has now been brought down to 6.

In January 1963 a senior psychiatrist filled a post transferred from Tara Hospital to the Johannesburg Hospital. By then the unit had become fully integrated to the hospital and had considerably developed its activity. Since the creation of the unit, weekly intensive case conferences have been attended by the members of the unit, students and external doctors. A staff meeting also takes place weekly and a follow-up is given on each patient in the wards. Informal contacts between members of the team take place whenever a problem concerning a patient arises. As the staff members came to know each other professionally and personally, a team spirit began to grow and each member of this team began to develop for himself a dynamic and changing role.

The patients are referred by medical practitioners in the community, by social welfare agencies outside the hospital, by doctors in the outpatient department, and from casualty where a psychiatrist is in attendance every morning from 11 a.m. to 1 p.m. Psychiatrists of the unit are also called for consultation by doctors in medical wards, and they have a diagnostic and a follow-up clinic in the outpatient department. The head of the department is Chairman of the Board of the Speech Therapy Clinic. The principal psychiatrist and the psychologist are on the Board of the Rehabilitation Unit. When the demand for beds is too great, acutely ill patients may have to be seen daily in casualty for support or warded under psychiatric supervision in a medical ward until such time as a bed becomes vacant in a psychiatric ward. Thus at any one time the unit carries many more than 32 patients. Psychiatric services are also available to nurses and other staff, and the head of the department attends personally to disturbed students.

All kinds of mental illnesses are seen, and it is the task of the unit to ascertain their aetiology and treat them or —if necessary—direct the patient to the suitable ward or institution.

Methods of treatment include all but insulin-coma therapy: chemotherapy; hypnosis; psychotherapy; electro-convulsive therapy, although less often administered than in years past; and occasionally narco-analysis. As a transition between ward treatment and complete return into the community, certain patients may become 'night patients' who go to work from the ward during the day, while others may become 'day patients' who come to participate in ward activities or occupational therapy during the day and go home at night. Until the end of 1964 each ward elected representatives, and held meetings during which ward matters were discussed and social activities were organized. But the population of the psychiatric wards of the hospital changed to more severely involved cases and these activities had to be suspended temporarily.

ROLE OF THE CLINICAL PSYCHOLOGIST

Early in the existence of the unit a need was felt for the contribution of a clinical psychologist towards diagnosis and psychotherapy. The mental illnesses that are seen in a general hospital have such varied aetiologies that it was necessary for the clinical psychologist to be versatile in his knowledge and in his approach, and in particular to be informed of the organic illnesses likely to present psychiatric symptoms. It was important that he should be able to recognize and assess deficits of neurological origin as well as to deal with the emotionally maladjusted patient.

Since the 1940s psychologists have been fairly well recognized as professional persons trained in the study and treatment of personality problems and, when necessary, they were requested to administer intelligence tests. But a psychologist who was trained to deal with deterioration, organic brain damage and severe mental illnesses was a rather unusual person at the time and, on joining the unit, I (L.M.C.L.) was apprehensive of the reactions of the various members of the team to these innovations. I also felt a great sense of responsibility to the patients as well as to my colleagues. But I was encouraged by the constant support of the head of the department and found myself in a group of young professionals animated by a keen pioneering spirit, whose cordiality made my efforts of adaptation rewarding. I was invited to explain my testing procedures, and interesting discussions took place. It became thereafter a tradition for me to give a talk on tests whenever changes took place so that an atmosphere of understanding was always present.

*Mrs. Joan Wolfsdorf, then Miss Joan Wayburn.

Referrals

Patients are referred for testing to the clinical psychologist by psychiatrists of the psychiatric team, by psychiatrists or other specialists attending the medical wards or the outpatient department, and by neurologists and neurosurgeons. Referrals are also made by the Rehabilitation Department, the Speech Therapy Clinic and the Hearing Clinic. The motive for referral is stated briefly. It includes the patient's main symptoms and the problems faced by the referring doctor, for instance: '? Hysteria ? epilepsy', '? epilepsy ? schizophrenia', 'Is this brain-injured patient fit to resume his former occupation? If not, what else could he do?' or 'This youngster has run away from school several times. What is the origin of this behaviour? Suggestions for treatment'.

Approach to Testing

Testing takes place in the psychology section of the psychiatry department. Patients who cannot walk are brought in wheel-chairs. The psychologist refrains from consulting the patient's bed-letter before testing him so as to avoid being influenced by the doctor's initial tentative diagnosis. She asks the patient a few questions about his age, standard of education, occupation, family situation, in order to make a brief assessment of his intellectual and emotional state and notes any obvious symptoms. This enables her to plan the testing procedure. If, after a short while, a test appears too difficult or unsuitable, it is replaced by a more suitable one and the next opportune moment is chosen so as not to perturb the patient. In exceptional cases the patient's grief or anxiety is such that he cannot cooperate in formal testing. Then an interview is given or the patient is taken back to the ward by the psychologist herself so that the patient does not feel rejected. Cooperation from the patients is usually good and the number of patients who refuse testing is negligible.

Tests Administered

The tests administered are classified into two main categories: (1) Tests of intelligence, maturation, deterioration and brain damage; and (2) personality tests.

1. In selecting an intelligence test the psychologist is careful to choose tests which have been standardized on the same kind of population as that to which the patient belongs. This applies particularly to age, and allowances are made for normal physiological deterioration. The patient's premorbid level is estimated from his educational and vocational achievements and familial background. Obtained results are then compared with expected results. Inter-test and intra-test variability is taken into account, and discrepancies beyond the margin of normal individual variation are noted as indices of deterioration, organic pathology or possible maladjustment. The patient's results are also compared with the results obtained by patients in various nosological categories and a diagnosis is suggested. For adults the most frequently used among intelligence tests is the Wechsler-Bellevue Interim Version, standardized by the National Institute for Personnel Research[13,18] and, for children, the South African Individual Scale.[6] The Wechsler Intelligence Scale for Children (WISC)[17] is also used with a few items adapted to South African conditions for brain-injured teenagers because it brings out inter-test variability in a striking manner.

Tests of maturation are administered to children who seem retarded, who have emotional or behaviour problems, or who are thought to suffer from brain damage. They include perceptivo-motor tests such as the Bender Gestalt Test[1] and Rey's Complex Figure,[15] which require the copying of geometric drawings, and Benton's Visual Retention Test.[2] They also include Porteus mazes[14] which are designed to measure intelligence defined as 'the ability to plan' and to take into account the consequences of one's actions. Another very useful maturation test is the Draw-a-Man Test[5] with its variation the Draw-a-Person Test. In scoring these two tests artistic ability is not taken into account, but points are credited for the items drawn (e.g. head, arms, legs, clothes) and also for correct positioning, proportions, avoidance of transparency through clothing, etc. Stages of maturational development have been found experimentally on large samples from an early age until puberty or adolescence, and the young patient's results are compared with the results obtained by other children of his age group. The Draw-a-Person Test has a special scoring system for adolescents and young adults who are mentally retarded.[3,9]

In contrast with tests of general intelligence, tests of maturation can be given to adults, because performance on these tests is not modified through experience ordinarily acquired in adulthood. Obtained scores lower than expected scores, important discrepancies between results on these tests, and tests measuring other intellectual functions indicate either a maturational defect or a dissolution of the corresponding function. Furthermore, these tests have been found to be sensitive to certain types of brain damage and psychiatric illnesses, and the types of errors or distortions produced by the patients have a diagnostic value. As far as localization of brain damage is concerned, verbal tests are specially sensitive to left hemisphere damage, while tests of spatial organization are particularly sensitive to right hemisphere damage. The description of finer methods of discrimination would be too long for the present paper.

2. Personality tests can be classified into: (A) Non-projective tests and (B) projective tests.

A. Non-projective tests include self-rating questionnaires, which help the patient to evaluate his character traits or his reactions in certain circumstances. They imply that he is capable of broad insight and of giving his full cooperation. They present a picture of the patient as he sees himself and as he wishes to be seen by others. In the psychology section of the Johannesburg Hospital it is felt that usually more ground can be covered by an interview than by straightforward questionnaires with the exception of two: the IPAT Anxiety Scale[8] and the Minnesota Multiphasic Personality Inventory (MMPI).[7] The IPAT differentiates covert from overt anxiety and, for this reason, obviates some of the weaknesses of self-rating questionnaires. It also allows the comparison of the intensity of various factors leading to anxiety, in particular the balance between drives, ego strength, fear of people in the environment, and guilt proneness. The MMPI enables the patient to rate himself (without knowing it) on scales corresponding to the classic nosological categories by endorsing or rejecting statements which have a discriminative value. Three validation scales reveal the patient's attitude to the test and to his pathology, and therefore eliminate some of the disadvantages of questionnaires. This test is used when there is serious doubt as to the diagnosis and type of treatment to be chosen, i.e. in borderline cases.

B. Projective tests are based on the notion of projection which has been defined by Healy, Bronner and Bowers[10] as 'a defensive process under sway of the pleasure principle, whereby the ego thrusts forth on the external world unconscious wishes and ideas, which, if allowed to penetrate into consciousness, would be painful to the ego'. These tests are therefore designed to give the psychologist access to areas of conflict which cannot be reached by other methods and which may be at the basis of the patient's maladjustment. Some conscious material is also expressed in this way. Projective techniques have been criticized on the ground that they leave too much scope for subjective interpretation. The approach and the vocabulary used in the report are inspired by the school of thought to which the psychologist belongs. However, when interpretations by various well-trained psychologists are compared it is usually not so much actual disagreements that are recorded as differences in emphasis and in depth of interpretation.

While projective tests help considerably in diagnosis, they are of even greater assistance in psychotherapy. They enable the therapist to adopt the attitude or give the interpretation

which makes the patient feel that he is understood, and this encourages him to come again for treatment. The projective tests used at the Johannesburg Hospital are (1) the Thematic Apperception Test (TAT)[12] and (2) the Blacky Test[4]—two picture tests eliciting fantasies and revealing the psychodynamics of the patient. While the TAT may reveal some basic preoccupations dating back to childhood, it deals largely with present-day problems. Some pictures representing important situations between two human beings often reveal familial and social tensions. Others, which are less structured, seem to have been retained by the author to elicit the unexpected and the unusual aspects of personality. While the second type of picture may appeal to the more intellectual patient, it does not inspire the majority of hospital patients. A second difficulty with the TAT is that it often brings out defences without eliciting the expression of needs, and the needs cannot be inferred by the interpreter because the picture is too loosely structured. The Blacky Test on the contrary is shorter, much more structured, and probes into the early psychosexual development of the personality as well as into some relationships and attitudes which are basic for adjustment in adulthood. It taps the various levels of consciousness and its thorough scoring system leaves few chances for any material to escape scrutiny. It is built on psychoanalytic concepts and is therefore of much use to the psychoanalytically inclined therapist. (3) The Rorschach Ink-Blot Test is used from time to time when the structure of the personality rather than the psychodynamics is sought and when a differential diagnosis is wanted, especially in cases of schizophrenia. (4) A test which is rapidly administered and interpreted is the Draw-a-Person test.[11] As previously mentioned, it gives reliable information on maturation and intelligence, but it also reveals useful data on areas of conflict particularly in patients who have difficulties in verbal expression. It has given striking results in schizophrenia.

Interviews

When a deep relationship between a patient and his psychiatrist has been reached, the psychologist limits herself to superficial contact with the patient and aims only at making him feel at ease in the testing situation. On the other hand, when only a superficial contact exists between doctor and patient, the psychologist sometimes gives an interview after the tests have been completed in order to obtain an over-all view of the patient's personality and problems. A second interviewer sometimes uses a different approach and gains access to problem areas which were hitherto unsuspected. However, once the case has been discussed by the team, the patient is handed to only one therapist if psychotherapy is chosen as the method of treatment.

Psychotherapy

A number of patients are referred to the clinical psychologist for psychotherapy, usually some time before they are discharged from hospital, and they are seen as outpatients from once a fortnight to twice a week. The psychiatrist originally in charge of the case is kept informed of progress and consulted at times when medication or readmission into a ward might become advisable. The type of psychotherapy given depends on the patient's illness, intelligence and insight. Some patients have been receiving supportive and directive therapy for a long period and have thus been maintained as useful members of the community instead of being institutionalized. Other patients receive a type of psychotherapy relying more on deep psychoanalytic interpretations. They give fairly good cooperation when they come, but there are certain practical problems: patients who work all day in the city or in industrial areas cannot come sufficiently often, especially if they live far from the hospital. They build up resistances between two sessions or they put themselves into complicated situations which they might have avoided had they been able to see the therapist earlier. The next session is then spent trying to solve urgent practical problems, such as payment of debts about which they have received summons, physical complaints, threats to be dismissed from work and even hunger, which they have neglected or mishandled until they saw the psychotherapist. In three instances patients with considerable resistances were treated by relaxation, light hypnosis and a mild form of deconditioning associated with interpretation. On follow-up, it appeared that 2 out of 3 had made the best readjustment they were capable of.

The psychiatric patients treated at the Johannesburg Hospital are usually very involved and few of them appear able to benefit by long-term psychotherapy. Even those who seem able to do so suffer from severe and deep emotional problems. Invariably, the home circumstances in childhood were disastrous and unfavourable to the development of the ego. Two examples will suffice to illustrate the point:

Case 1

A girl aged 20 years came to ward 28 after an overdose of barbiturates following an induced abortion. She suffered from nightmares which terrified her and she was sometimes overcome by an uncontrollable impulse to scream. Her alcoholic father had left her mother penniless with 6 children. They had lived barefoot in an old garage. When the mother died the children were adopted by various uncles and aunts, who were not on speaking terms, and the patient was separated from the baby brother whom she had cared for since she was 6 years old. The relative who had adopted her was an uncertifiable borderline schizophrenic and the girl had to run away from home with only the clothes she wore. Her need for love and her need to have a child—somebody that belonged to her and would love her—was tremendous. She was treated by relaxation, light hypnosis and interpretations, not only during day interviews but also sometimes at night by telephone when she felt the impulse to scream. In spite of all the support of the therapist and in spite of the fact that the therapist was assured that she was aware of methods of birth control, she fell pregnant again. Her young man was prepared to marry her, but she was still in love with the father of her first child and, repeating a masochistic pattern she had been adopting for a long time, she discouraged him by her behaviour. After her former guardian had come to insult her at her place of work, she lost whatever self-confidence she might still have had and she was finally admitted into a home for unmarried mothers outside Johannesburg.

Case 2

A young man of average intelligence, aged 20, was referred to ward 33 for anxiety and fainting attacks which raised the question of epilepsy. No signs of organicity were found either in the medical or in the psychological tests. Although he was not naughtier than other schoolboys, his mother used to punish him excessively. On a number of occasions she made him lie on the kitchen table and thrashed him till he bled. His father was often working far away from home and was not particularly interested in his children. One night, when the patient was 9 years old, he left the bedroom where he was supposed to be asleep and came into the lounge to fetch something. He found his mother having intercouse with a man while another man was waiting in the lounge as well. He and his brother were removed from home when he was 12, and they were placed in an orphanage. They hardly ever received visits and were not close to each other. The patient left the orphanage sometimes to stay with a farmer who gave him hospitality during the holidays. Although he could have pursued his studies he left school to become an apprentice and

acquire some independence. His sexual education was very limited. He took a girl out a few times and had intercourse with her on the spur of the moment. She was an adopted child and was on good terms with her adoptive parents. When she found herself pregnant her parents told him that he did not have to marry her, but he felt a sense of responsibility and married her although he did not love her and felt too young to get married. Because of financial stringency they came to live with the girl's family where he felt ill at ease. He found their conversation and arguments futile and they were irritated because he did not take part in them. There was considerable opposition on their part to his coming for psychotherapy. He was torn between his sense of paternal duty and his need to escape and be free. He felt, however, that his relationship with his wife and his own condition would improve when they could settle again in a flat of their own even in spite of his wife's inexperience about babies. He resumed work and attended psychotherapy for 2½ months. The rapport with the therapist was sound, but he interrupted treatment without notifying her. Before he came for the last two sessions, his wife and mother-in-law had harrassed him with personal questions about his treatment and insinuated that he was carrying on an affair with the therapist. The therapist had offered to see the wife, but the wife did not avail herself of this opportunity. In spite of the patient's clear explanations about the nature of the therapeutic relationship she may have succeeded in dissuading her husband from coming again.

Group Psychotherapy

During the first two years of the unit's existence the psychologist participated in or was in charge of group psychotherapy which gathered men and women patients and staff together. Some very interesting sessions took place and the problems of depression and anxiety were discussed. However, the type of patients treated in the wards changed progressively in the later years. The number of organic and psychotic cases increased to such an extent that group discussions were no longer possible. Short talks were given by a psychiatrist or the psychologist during an interim period, then group therapy was abandoned.

Training of Clinical Psychologists

Since the Johannesburg Hospital is a teaching hospital, the clinical psychologist is a member of the staff of the University of the Witwatersrand. As such she trains future clinical psychologists in testing procedure, especially as far as intelligence, maturation, deterioration and brain damage are concerned. Students are able to test selected patients under her supervision and thus acquire experience in differential diagnosis.

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