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THE REVOLVING DOOR SYNDROME: A SYSTEMIC APPROACH

by

DESIREE PRISMAN
THE REVOLVING DOOR SYNDROME: A SYSTEMIC APPROACH

by

DESiREE PRISMAN

submitted in partial fulfillment of the requirements for the degree of

MASTER OF ARTS

in

CLINICAL PSYCHOLOGY

in the

DEPARTMENT OF PSYCHOLOGY

at the

RAND AFRIKAANS UNIVERSITY

Supervisor: Professor D. Beyers

January 1993
"There is a gap between experience of the world and the abstract mechanistic scheme of science which Holism is made to bridge. This gap is probably responsible for much of that strain in the world of to-day, and with the deep disappointment with the social effects of science, which is more and more assuming the alarming proportions of a revolt against science itself."

The Thoughts of General Smuts. 
Compiled by his Private Secretary: P.B. Blanckenberg (1951)

Dedicated to my mother and father
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ABSTRACT

The aim of this dissertation is to investigate the services and methods provided by the various medical and psychological professions within an inpatient psychiatric hospital setting. While working at a psychiatric hospital, the researcher was struck by the high readmittance rate of patients. This tended to create a general feeling of disappointment, frustration and impotence amongst the professions. The importance of such an investigation was therefore required, in order to help facilitate and improve current methods.

A thorough investigation of the literature with regard to the current treatment methods at psychiatric hospitals, both on an international and national level, were undertaken. An in-depth case study was described and analysed to indicate the recurrent procedures, methods and treatment modalities that were being instituted within the hospital setting.

The aim of this thesis was also to propose an alternative method to the current procedures, using an in-depth case study to indicate the use thereof.
OPSOMMING

Die doelwit van hierdie verhandeling is om die dienste en metodes van verskeie mediese en sielkundige beroepse, in die konteks van psigiatriese hospitaal vir binne pasiënte, te ondersoek. Gedurende haar werksaamhede in 'n psigiatriese hospitaal het die hoe voorkoms van pasiënt-heropnames die navorser opgeval. Hierdie fenomeen het geneig om 'n algemene gevoel van teleurstelling, frustrasie en hulpeloosheid onder die professionele personeel in die hand te werk. Die belang van hierdie studie is gesien as noodsaaklik ten einde huidige metodes te faciliteer en te verbeter.

'n Deurtastende ondersoek van die literatuur met betrekking tot huidige behandelingsmetodes, op nasionale sowel as internasionale vlak, is onderneem. Voorts is 'n diepe gevallestudie beskryf en geanaliseer, ten einde die prosedures, metodes en behandelingswyses wat binne hospitaalverband herhaaldelik gebruik word, aan te toon.

Die doelwit van die verhandeling sluit ook 'n voorstel in van 'n alternatiewe metode van behandeling, in teenstelling met huidige metodes. Die gebruikswaarde van die alternatiewe metode word aan die hand van 'n gevallestudie toegelig.
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CHAPTER ONE

OVERVIEW

1.1 Introduction

When patients are admitted to a hospital, it is expected that they will be diagnosed and treated appropriately. Multi-disciplinary professionals - including the psychiatrists, psychologists, social workers, occupational therapists and psychiatric nurses - take their responsibility seriously and help in many ways.

What is often not taken into account is that patients admitted to a psychiatric hospital are often people admitted for a second, third (and more) times.

It appears that these patients are more often than not, treated as readmissions, but the relevant diagnostic admissions do not take cognisance of the fact that the process of admission could be part of the patients' total problem. There is a tendency to readmit them as newly admitted patients, wherein they are diagnosed according to their current symptoms. Readmitted patients are often referred to as "having another episode" or displaying "new symptoms" and therefore their initial diagnosis/label according to the DSM-III-R is often changed.
This has given rise to the concept of the "revolving door syndrome" - which can be defined as the process describing those discharged psychiatric patients who are subsequently rehospitalised and who repeatedly require admission to hospital, often as involuntary patients (Anthony, 1980; Sensky, Hughes & Hirsch, 1991).

1.2 Consequences of Reductionism versus Ecosystemic Thinking

The hypothesis of this dissertation is that the revolving door syndrome is the result of the traditional linear treatment approach. This unfortunately leads us to the question of the efficacy and efficiency (or otherwise) of the helping professions. In order for suitable improved treatment programmes to be instituted it is submitted that questions should be reframed so as to ask how the revolving door syndrome can be re-hinged on the basis of the new information obtained from systemic thinking.

The ecosystemic paradigm was chosen as a model for the investigation of readmissions. This approach/epistemology recognises that truth is relative and thus attempts to expand, question and combine the reality of the researcher with that of the patient into the widest possible view of reality. It also recognises that "reality is generally socially constructed and thus searches for patterns of relationship which connect all living things as a way of constructing reality. The contexts in
which the patterns occur, fix the meanings and are thus considered an important part of reality. The therapist and patient together interact to form the process of research" (Wittstock, 1989, p. 7).

Ecosystemic research can be summarised as participant observer research with both therapist and patient having unique views of reality which can be combined to give a view of views or a metaview of reality (Wittstock, 1989). In other words, the emphasis is not on parts but on wholes and the patterns which connect the wholes. The epistemology holds that observers should always be sensitive to simple and higher orders of recursion (Keeney, 1983). The epistemology thus advocates a dialectical approach which allows us to comprehend the dynamic relations among systems. It allows us to transcend the dichotomies which exist between systems, and address the interfaces between them (Webster, 1989).

In line with these concepts, human behaviour and interaction are understood as communication processes and psychopathology is regarded as part of the interactive process. Symptoms are understood not as the manifestation of the mental illness of an individual, but as having meanings in the relationship patterns of the family. Readmissions can be seen as an important part of a family's attempt at maintaining its interactional patterns. While in the "hospital the patient is removed from the family and its interactions and recovers. On return to the family, the
interaction patterns continue as before and the symptoms may recur. Investigation of readmission will thus focus on the interaction patterns in the family which maintain the symptoms of a member as well as the wider context of the patient's life" (Wittstock, 1989, p. 8). The results of the investigation will be formulated as hypotheses concerning both the family's maintenance of relationship patterns in the face of change and about the role of the wider contexts of a patient's life in the development and recurrence of his/her "illness" (Wittstock, 1989).

This ecosystemic view of change holds that linear causality is not possible. However, one may have the psychological experience of causality if one uses interventions which "fit" the structure of the systems involved. Planned interventions should therefore be isomorphic with the system involved. They should also take into account the complex interrelationships which exist between co-evolved systems (Webster, 1989).

1.3 Motivation for this Research

Although there is a dearth of international and national research studies, evidence has tended to support the revolving door
syndrome. This has also been this researcher's experience in a large state psychiatric hospital, where she had been working during her twelve month internship. She was struck by the high readmission rates of patients. This researcher became aware of the presently "more of the same" treatment procedures being instituted. She felt distressed at how the system viewed "psychopathology". It was seen in isolation, with the aim of finding symptoms in the patient. If the patient fitted a certain category or list of symptoms, the patient was diagnosed and given a "label". Drug therapy was seen as the main focus of treatment, almost to the exclusion of other therapeutic interventions. Psychotherapy seemed to have a limited place in the psychiatric hospital.

The main aim in the hospital, so it seems, is to diminish/"cure" the presenting symptoms - so that the patient can be discharged as soon as possible. This view is based on past research studies, where it was thought that deinstitutionalisation would reduce chronicity and hospital dependence as well as leading to a reduction of the financial costs to the state. However, multiple readmissions have indicated otherwise (Geller, 1982).

1) Throughout this thesis the term "researcher", when used in the third person, refers to the author of this dissertation, both in her research role and as a therapist.
The "more of the same" treatment procedures, have also led us to question the effectiveness of the diagnosis and treatment procedures found in psychiatric hospitals (Watzlawick, Weakland & Fisch, 1974; Haley, 1980).

It is proposed that the understanding of health and pathology needs perhaps to be revised. A change in one's mode of thinking and operation is required. In other words, an epistemological shift is required. Ecosystemic epistemology gives rise to a model of mental health and pathology which transcends the reductionism of the other models.

An either/or model is not proposed, as this would again emphasise reductionism. Thus, a combination of the two models is recommended, in order for the ultimate benefits to be achieved.

1.4 Aims of the Study

The main aims of this study are to:

1.4.1 pinpoint the general themes occurring in the literature of readmitted patients;
1.4.2 pinpoint possible unresolved issues and problems in the diagnosis and treatment of 'mentally ill' patients;
1.4.3 investigate the occurrence of these themes in a one-case study of a readmitted patient;
1.4.4 consider the process of intervention (i.e. diagnosis and treatment) on the basis of these themes as observed in the case study.

An in-depth literature review of the revolving door syndrome was undertaken. Furthermore, an in-depth case study was described and analysed, wherein various hypotheses of the patient's readmissions were presented. In this way an alternative treatment approach to the present orientation of treatment within the psychiatric hospital, is proposed.

Some of the content and the names of the individuals in the case study to be discussed have been altered, so as to preserve the confidentiality of the client system.

1.5 Organisation of the Dissertation

Chapter 2 is an examination of the literature of the concept of mental illness viewed from a medical model's point of view and of readmissions to psychiatric hospitals as seen both on international and national levels.

Chapter 3 outlines the ecosystemic epistemology and motivates its use as an alternative theoretical base for diagnosis and treatment. This approach also allows for the combination of views of the therapist and patient, facilitating a metaview of the problems associated with readmission and is the basis for
this investigation.

Chapter 4 presents the in-depth case study from which hypotheses were developed about readmissions. An alternative treatment procedure was instituted.

Chapter 5 provides a summary and conclusion of the thesis with various recommendations to help diminish the revolving door syndrome.
CHAPTER TWO

THE "REVOLVING DOOR SYNDROME"

2.1 Introduction

The aim of this chapter is to investigate the literature relevant to readmissions on an international level and to compare it to the South African context. Much overseas research has been done on the high readmission rates. Investigations have focused upon the types of patients, diagnoses, lengths of stay and treatment aspects as important factors in determining the readmission rates of patients. In South Africa, research has uncovered the same trend of high readmission rates and the problems linked with readmission.

The issue of readmission of psychiatric patients has been the subject of investigation in the Western mental health field throughout the seventies and eighties (Wittstock, 1989). As a result of the move towards deinstitutionalisation of chronic patients in the sixties, the number of psychiatric residential inpatients has decreased. The community mental health movement started in order to provide facilities to maintain psychiatric patients living in the community rather than having chronic long term patients in state mental hospitals. It was thought that long term hospitalisation promoted chronicity and dependence.
The services were to provide a substitute for long term hospitalisation and a support for patients after discharge (Woolley & Kane, 1977; Kirk, 1979 in Wittstock, 1989). The result has been a decrease of inpatient populations but a rise of admissions of short term patients who become multiple readmissions (Geller, 1982; Gillis, Sandler, Jakoet & Dickman, 1985; Pablo, Kadlec & Arboleda-Flores, 1986, in Wittstock, 1989).

This deinstitutionalisation eventually led to a torrent of literature exposing the sufferings of discharged patients, particularly those who had been shunted into inferior proprietary homes or who had adopted a semiderelict status in the community (Geller, 1982). The vicious cycle of readmissions has been termed the "revolving door syndrome". The "revolving door" has "denoted the fate of a smaller group of patients: those who began to be repeatedly readmitted to hospitals and discharged in an apparently purposeless fashion" (Geller, 1982, p. 388). In everyday hospital conversation, "the revolving door" has become a catch-phrase, an image of despair and cynicism, adopted casually and often carelessly (Geller, 1982). It was thought that the deinstitutionalisation movement would eliminate chronicity but this has not proved to be so. The revolving door population has been considered a by-product of the process of deinstitutionalisation, and it has been interpreted as a failure of the psychiatric services to deal adequately with the patients' requirement since this group of patients require rapid
readmission (Kastrup, 1987).

In the literature the terms "revolving door patient" and "recidivist" are sometimes used interchangeably. Geller (1982) notes that "recidivism" is an interesting term in that its use underscores the traditional link, in the public eye, between the mental patient and the criminal. Definitions of recidivism in medical dictionaries consistently interlace references to criminology with references to mental illness. With time, the term revolving door was applied with increasing frequency to mental patients without criminal records (Geller, 1982). And in the "1970s, when studies were mounted to investigate the effects of neuroleptics, psychotherapy, halfway houses, and rehabilitation programmes on recidivism rates, the term recidivism also shed its forensic origins and became applicable to vast numbers of civil cases" (Geller, 1982, p. 388).

Subtly, the term revolving door points the finger of blame at the "system", while the use of recidivism indicts the patient him/herself. The system's faults are said to include "poor continuity of care, inadequate rehabilitation facilities, and legislative and judicial contradictions" (Geller, 1982, p. 388). The recidivist patient's faults are listed as "noncompliance with drug regimens, ambivalence, and the cyclical character of mental illness" (Geller, 1982, p. 388). Nevertheless, Geller (1982) points out that in a review of the literature and in their own thoughtful study, Rosenblatt and Mayer (1974) conclude that a high number of previous admissions is the only factor that
correlates with a patient's tendency to return to the hospital. They suggest that there is a type of patient, independent of symptoms, diagnosis, or attempts at therapeutic intervention, who prefer to operate subject to the revolving door, or, as Rosenblatt and Mayer (1974) put it, to "ride the shuttle" (in Geller, 1982, p. 388).

Furthermore, Geller (1982) explains the way in which classically psychotic patients develop, through adjustment to the social systems imposed on them, a sociopathic style of functioning wherein their symptoms become "means to an adaptive end" (p. 389). He suspects that many archetypal revolving door patients develop in this fashion, gradually adopting the revolving door as an ego-syntonic life style. Hence, they become "recidivists", sharing, through their apparent sociopathy, a name also applied to habitual criminals. They are "passive victims of the revolving door in that it is a social mechanism imposed on them by means of economic, political, philosophical, and legal contradictions, and they respond to it actively as recidivists, in that the social mechanism dovetails with their own internal contradictions and ambivalence" (Geller, 1982, p. 389).

The revolving door may validly be seen as a regressive position held by both the patient and his society. This kind of cyclical movement is a "typical feature of primitive functioning, and is tempting to fall back on when neither patient nor society feels capable of solving difficult problems in a more sophisticated
way" (Geller, 1982, p. 389). Geller (1982) has asked whether the revolving door "solutions" should be seen as a trap or a lifestyle!

Many authors describe the effects of hospitalisation. Hospitalisation leads to dependence and helplessness which become solutions to the patients' developmental and adaptational problems and previously hospitalised persons expect another hospitalisation in times of stress (Sheridan & Teplin, 1981, in Woogh, 1986; Chandrasena & Miller, 1988). The environment of modern hospitals, with plentiful social interaction, fulfils the needs of patients better than their own homes, causing many patients to wish to remain in or re-enter hospital (Rosenblatt & Mayer, 1974, in Woogh, 1986). Effective treatment of patients who, independent of symptoms, diagnosis, or therapy, prefer the revolving door process, is extremely difficult (Geller, 1982; Woogh, 1986; Chandrasena & Miller, 1988).

2.2 Current Focus of Treatment at the Psychiatric Hospital

2.2.1 Conceptualisation of Mental Illness

It is important to note that the researcher is neither criticising nor stating that there is one preferred method of working. To do so would once again result in reductionism. Each school of thought has its own contribution and significance. One's own orientation will determine one's "reality" for working
and understanding the "wonders of life". The aim is to make us aware of other ways of working and seeing whether other methods can in fact help what is happening in the system. Variation results in "multiple realities", and we need to be aware of the importance of each and every orientation/contribution with which we are faced.

In the psychiatric world of understanding pathology, it is necessary to be aware of the orientation form in which the psychiatrists are trained. However, because psychiatry's scientific outlook relied less upon objectivity than any of the other medical disciplines, an uneasy association, at best, and a hostile chasm, at worst, developed between psychiatry and the rest of medicine. When "real" doctors accused psychiatry of lacking scientific integrity, some psychiatrists were quick to point out that objectivity was not a requirement for scientific legitimacy (Williams & Johnson, 1979). Thus, the scientific mode of psychiatric inquiry has relied primarily upon disciplined subjectivity rather than upon measurable objectivity (Williams et al., 1979) which is called "truth" and "unquestionable pathology". Upon this understanding, psychiatrists still find it essential to objectively diagnose and label pathology, leading to the idea of reification.
2.2.1 Psychiatric Diagnosis - The Medical Model

Through the development of ECT and antipsychotic and mood-regulating agents, psychiatric diagnosis was no longer a mere academic exercise. Substantial unreliability of psychiatric diagnosis vitiated its usefulness in determining pharmacologic interventions. A major reason for the unreliability was that clinicians used different criteria for making psychiatric diagnoses. This problem was reduced significantly by the application of specific diagnostic criteria for each nosological entity. DSM-III-R was thus used to discourage clinicians from reaching premature diagnoses. By paying closer attention to diagnostic criteria, practitioners place a greater focus on objectively describing patients' clinical features. Its descriptive approach necessitated a reliance on symptom-oriented and historical data in the formulation of diagnoses.

The problem arising from this way of thinking is that the result is a reductionistic way of viewing human life, in that it has a tendency to think of causation in lineal, unifactorial terms. It leads to a tendency to look only at the body and parts of the body preferring to punctuate the individual as a whole and to regard other supra systems as irrelevant. It conforms with the fallacy of biological reductionism wherein it is believed that all mental illnesses are purely biological or biochemical in origin. Any form of reductionism, results in simplifying the
issue at hand and thus not realising the complexification of human life.

2.3 International Research on Readmissions

Much research has been done on readmissions, but the results are complex. Readmission has been used as a measure of treatment failure by some researchers and focus has been placed on revision of hospital treatment modalities as a means of preventing readmissions. Some researchers regard readmission as treatment failure only if it is for the same problem, while others regard readmission as necessary in order to compensate for the shorter treatment received in the hospital (Franklin et al., 1975 in Wittstock, 1989). The disadvantage of hospital treatment focus is the multiplicity of factors involved in readmission (Gillis, Sandler, Jakoet & Dickman, 1985).

Pepper (1987) identifies two major problem areas associated with readmissions which are related to treatment:
(a) a lack of integration between inpatient and outpatient services and resultant loss of contact with the patient and
(b) the fact that psychiatry and state mental health services do not provide a holistic treatment. Mentally ill persons are regarded as discrete entities and no attention is given to precipitating environmental factors either in hospital or on discharge.

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In other words, treatment seems to focus on a scientific, reductionistic, linear orientation, whereby the main focus is on medication which leads to ignoring other important contributing variables to the system. This leads to the "more of the same" treatment procedures being instituted. This in turn continues the vicious cycle of readmissions, as no holistic change is being brought about to the maladaptive functioning of the system. Clinicians and researchers have been interested in profiling this subgroup of recidivists in an attempt to identify the variables contributing or relating to their recidivism.

Casper and Pastva's (1990) results suggested that the general "heavy" user population (of state psychiatric hospitals) may be a composite of smaller subgroups that may be quite different from each other in their biographic, demographic and clinical profiles. They suggest however, that it may be misleading to characterise the "heavy" user on the basis of a general, global profile. Throughout the whole sample the highest common factors were programme and medication non-compliance and denial of illness. Indeed to a lesser extent "never being married" and a history of substance abuse were also found to exhibit a high incidence and low variability. These variables (characteristics) may be most distinctive of the "heavy" user, and could have the effect of discriminating them from the general hospitalised population (Casper & Pastva, 1990). Other studies have shown that prior hospitalisation history, chronicity and severity of
illness, delusional beliefs, social disengagement, and a history of assaultative behaviour predict high hospital utilisation, while positive family environment predicted fewer days of rehospitalisation (Colenda & Hamer, 1989).

Other recent studies substantiated these findings. They found that the variables affecting rehospitalisation included the number of previous admissions to hospital, marital status, age, symptomatology, compliance with aftercare, living situation and social support (Boydell, Malcolmson & Sikerbol, 1991). Colenda and Hamer's (1989) study further supported several conclusions about young adult patients derived from previous research. In general, patients with major mental illnesses, such as schizophrenia, are more likely to stay in hospitals longer and require hospital readmission, regardless of past psychiatric hospitalisation history. In addition, patients who had longer index hospital lengths of stay were more likely to have rapid readmissions. Kastrup's (1987) previous findings in Denmark supported this notion, indicating that revolving door patients were significantly more likely to have the diagnoses "schizophrenia", "personality disorder", "alcohol or substance abuse".

Zilber, Popper and Lerner's (1990) study in Israel found that the diagnosis of affective disorder was related to shorter duration of inpatient stay but to earlier readmission. Schizophrenic patients were those who accumulated the largest inpatient stay,
mainly due to repeated readmissions. Thus, the diagnostic group seemed to play an important role in the determining factors of readmission.

A seven-year follow-up study until 1991, of patients with functional psychoses was undertaken in Norway, supported this notion (Friis, Hauff, Island, Lorentzen, Melle & Vaglum, 1991). Results indicated "diagnoses" as a powerful predictor of outcome. The schizophrenic patients had a rather poor outcome. A rehospitalisation rate of 86% and an average hospitalisation time of seventeen months over a seven-year period seem to be somewhat high. Much supported research substantiates this finding (Wooogh, Meier & Eastwood, 1977; Kastrup, 1987; 1987; Lewis & Joyce, 1990; Casper & Pastva, 1990; Zilber, Popper & Lerner 1990; Geller, 1992).

Other important variables ascertained through the research were age and gender. A nation-wide study in Denmark found that 21% of all young males below 25 years of age that were single, divorced and unemployed became revolving door patients (Kastrup, 1987). This finding was substantiated by other research studies such as those of Wooogh, Meier and Eastwood (1977) and of Lewis and Joyce (1990). Male revolving door patients most commonly were given diagnoses of schizophrenia, personality disorder and addictive disorder, whilst female recidivists were most commonly given diagnoses of manic depression, psychogenic psychosis and neurosis (Lewis & Joyce, 1990).
Differences in admission rates appear between urban and rural areas (Kastrup, 1987). In a Danish census of patients in psychiatric institutions the prevalence rate varied with the highest rate in the capital compared with the rest of the country and with this difference almost equally pronounced in all age groups. It was found that the revolving door phenomenon in males particularly was a problem of the larger cities, whereas the degree of urbanisation seemed less important in females (Kastrup, 1987).

These similar findings on an international level must raise questions as to what extent patterns of readmission are influenced by differing arrangements for mental health services, and to what extent patterns of readmission are more directly caused by the very nature of psychiatric disorders.

In Lewis and Joyce's (1990) study of a cohort of patients over a five-year follow-up period, it was found that young psychotic patients are those at greatest risk of becoming revolving door patients. All young patients with functional psychoses, and not just those with schizophrenia, were at high risk of becoming revolving door patients. However, in what they call the newly defined revolving door subgroup i.e., those patients who had four or more admissions to a psychiatric hospital within the five years following their initial admission) schizophrenia patients predominate. Some young patients with an initial diagnosis of
schizophrenia subsequently have their diagnosis changed to bipolar disorder (Joyce, 1984, in Lewis & Joyce, 1990), and these figures for schizophrenia may be inflated by this misdiagnosis. Further, the new revolving door population also contains a large group of women with neurotic depression and of men with substance abuse (Lewis & Joyce, 1990).

**TABLE 1**

Percentage of patients by diagnosis and age group that become revolving-door patients (numbers in brackets give the number of subjects in the total group)

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Schizophrenia</th>
<th>Mania</th>
<th>Depressive psychoses</th>
<th>Other psychoses</th>
<th>Organic disorders</th>
<th>Neurotic depression</th>
<th>Other neurotic disorders</th>
<th>Personality disorder</th>
<th>Alcohol dependence</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤24</td>
<td>40%</td>
<td>42%</td>
<td>22%</td>
<td>36%</td>
<td>15%</td>
<td>11%</td>
<td>10%</td>
<td>11%</td>
<td>9%</td>
</tr>
<tr>
<td></td>
<td>(154)</td>
<td>(12)</td>
<td>(46)</td>
<td>(47)</td>
<td>(48)</td>
<td>(237)</td>
<td>(52)</td>
<td>(151)</td>
<td>(64)</td>
</tr>
<tr>
<td>25–34</td>
<td>28%</td>
<td>30%</td>
<td>11%</td>
<td>20%</td>
<td>12%</td>
<td>9%</td>
<td>11%</td>
<td>16%</td>
<td>8%</td>
</tr>
<tr>
<td></td>
<td>(122)</td>
<td>(43)</td>
<td>(76)</td>
<td>(54)</td>
<td>(31)</td>
<td>(316)</td>
<td>(63)</td>
<td>(87)</td>
<td>(87)</td>
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| Total subjects | 409 | 110 | 321 | 142 | 185 | 1050 | 242 | 297 | 365 |

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| Total subjects | 427 | 67 | 198 | 193 | 173 | 479 | 119 | 331 | 1333 |

(From: Lewis & Joyce, 1990, p. 132)
Readmission rates, however, have many limitations as a method of service evaluation. Many factors influence readmission rates. Some treatment programmes aim at early recognition of relapse and early hospitalisation, with the objective of shortening the duration of the episode of illness and/or minimising social dysfunction arising from the disorder. Lewis and Joyce (1990) note that it is most important that readmission rates are not seen as measures of the effectiveness of treatment programmes, but that it be acknowledged that hospitalisation is likely to remain one part, but an important part, of total treatment programmes for psychiatric patients. The evaluation of programme effectiveness should be based on "patient measures such as quality of life, social functioning and persistence of symptoms, rather than on measures of service provided, such as readmission" (Lewis & Joyce, 1990, p. 134).

Kastrup (1987) further notes that no single factor seems decisive in predicting between good or bad prognosis. He points out that the question of psychiatric readmission is complex and multifaceted and using readmissions as an indicator of success or failure is a kind of reductionism. "Readmission is a reflection of a number of components, the conditions in the patient himself, his family, the community and the psychiatric institution, and no single instrument can measure them all" (Kastrup, 1987, p. 82).
Boydell, Malcolmson and Sikerbol's (1991) results from their Canadian study indicated that the majority of patients discharged from a large psychiatric facility (86%) were referred to other services in response to their identified needs. Visits to an aftercare agency or service were made by 72% of the cohort before discharge and 86% made a visit after discharge from the hospital. Readmission to hospital within three months of being discharged was not related to inadequate housing, lack of compliance with their medication or losing touch with the aftercare services. Rather, the major factors were behavioural manifestations of severe illness and personality/temperament characteristics.

Boydell et al. (1991) note that the patients who were readmitted to hospital within three months were found by the staff to exhibit significantly more uncontrolled outbursts, unexplained mood changes, and to be more irritable and anxious than those who were not rehospitalised. Contrary to this, a study of 700 admissions to a provincial psychiatric hospital in Canada found that patients at high risk for recurrent hospitalisation were characterised more by paucity of environmental supports than by clinical symptoms or diagnosis (Woogh, 1986).

Woogh (1986) further notes in a comprehensive review of the studies on readmission of psychiatric patients, that the only variable that consistently predicted readmission was the number of previous admissions. Other variables such as diagnosis,
demographic characteristics and follow-up outpatient treatment were less useful. Marsh, Glick and Zigler (1981) found that the greater the coping potential of the patient, the greater the likelihood that the patient will have an initial hospitalisation of short duration, and the less likely will be the possibility that the patient will be rehospitalised. In their study, no evidence was found to indicate that the patient's diagnosis influenced the premorbid competence-outcome relationship. In fact, the relationship discovered between diagnosis and outcome suggest that premorbid competence and diagnosis may make independent and distinct contributions both to length of initial hospitalisation and to rehospitalisation.

2.4 Research in South Africa on Readmissions

Multiple readmissions seem to be a world-wide phenomenon accompanying the Western mental health movement to deinstitutionalisation. South Africa seems to be no exception to this trend. The effectiveness and relevance of mental health treatment and outpatient services in South Africa are being questioned (Bassa & Schlebusch, 1984; Gillis, Sandler, Jakoet & Dickman, 1985; Medical Research Council, 1987; Visser, 1987, in Wittstock, 1989). The pattern of readmissions to psychiatric hospitals seems to be the same as that noted in the international literature - high patient turnover with shorter hospital stay and increased readmissions. The latest available collated statistics for example, in regard to a single psychiatric
Reasons for readmission have been highlighted by Gillis et al. (1985). Poor quality and inadequate outpatient and hospital services seem to be the primary factors involved in readmission. The focus of treatment is the medical model which advocates symptom removal by medication which seems to be inadequate.

Socio-economic and political conditions in South Africa play an important role in readmissions. The poorer, disadvantaged people, particularly in the black and coloured communities were
not able to get the support of family doctors, private clinics, psychiatrists, social welfare and crisis services (Wittstock, 1989). Families cannot afford an extra mouth to feed. Thus, if a member is out of work due to illness, the relatives seek admission, especially if the channel to the hospital has been opened by previous admissions (Wittstock, 1989).

Other factors found to precipitate readmission are poor compliance with medication and drug and alcohol abuse (Gillis et al., 1986). Poverty and lack of education and distance from clinics are additional reasons for high default rates.

2.5 Important Treatment Variables/Aspects

2.5.1 Social and Family Life

In general, on the international and national field, the social and family life of the patient is seen as a major factor in the development of mental illness and determination of relapse (Marsh, Glick & Zigler, 1981; Harris & Bergman, 1984; Silverstone & Romans-Clarkson, 1989; Hiday & Scheid-Cook, 1991; Rea, Strachan, Goldstein, Falloon & Hwang, 1991; Rosenfield, 1991; Vaughan, Doyle, McConaghy, Blaszczynski, Fox & Tarrier, 1992). It has been found that the breakdown of social networks are associated with patients' entrapment in the revolving door syndrome (Dozier et al., 1987, in Wittstock, 1989). The quality or absence of a patient's network system affects his/her mental
well-being. Patients with families of high density network, or enmeshed families and those of low density network, or poorly connected families, seemed to be linked to high readmission rates. Enmeshed families allow the patient little interpersonal distance, while low density families encourage alienation and withdrawal. Consequently when everyday needs arise or, worse, when a temporary crisis erupts, chronic mental patients often have nowhere to turn but the state hospital. Overutilisation of the hospital as a crisis management strategy may thus be linked to failure of the support system to meet patients' needs (Harris & Bergman, 1984). Often when staff members speak with the relative, they discover that the person has had no contact with the patient for a long period of time, that the last encounter was stormy and ended with a call to the police, and that under no circumstances was the patient allowed to return home. This kind of misperception (lack of insight) of other people's intentions and feelings often results in the patient being rejected and turned away by others and may increase the likelihood of rehospitalisation.

Medium density networks however, provided the lowest readmission rates and researchers advocated working with these patients and their families to facilitate appropriate connectedness amongst members (Wittstock, 1989).

There is now a considerable body of research investigating the association between schizophrenic relapse and the level of
Expressed Emotion (EE) of the relatives to whom the patient returns to live with after hospital discharge (Kuipers & Bebbington, 1988; Falloon, 1988 in Vaughan et al., 1992). Typically patients are recruited into the study during an admission for an acute schizophrenic episode. During the admission the relatives living in the same residence are interviewed using the Camberwell Family Interview (Leff & Vaughn, 1985) which is audiotaped. From this audiotape three measures - criticism, hostility, and marked emotional overinvolvement (EOI) - are assessed and on the basis of these scores the relative is assigned to either a high EE or low EE category. After discharge the patients are followed up over a nine to twelve month period during which relapses, defined in terms of a worsening or recurrence of positive symptoms, are noted. A comparison between the number of relapses in patients returning to live with high and low EE relatives is then made.

A number of international studies have used this methodology and confirmed the finding of a significantly greater number of relapses in patients returning to live with high EE relatives. However, two studies, one carried out in Germany (Kottgen, Sonnichsen & Mollenhauser, 1984, in Vaughan et al., 1992) and the other in Australia (Parker et al., 1988, in Vaughan et al., 1992) have failed to find any association between relapse and EE. These two studies show a number of methodological differences and defects especially in relapse identification which could explain their negative results (Vaughan et al., 1992).
These studies of EE stimulated the development of family-focused interventions, designed to modify the attributes of intrafamilial relationships believed to increase the risk of relapse (Rea et al., 1991). Five controlled trials have reported substantial reductions in relapse when family therapy was added to maintenance drug treatment (Goldstein & Rodnick, 1978; Leff, Kuipers, Berkowitz et al., 1982; Falloon, Boyd, McGill et al., 1982, 1985; Hogarty, Anderson, Reiss et al., 1986; Tarrier, Barrowclough, Vaughn et al., 1988, in Rea et al., 1991).

Other factors appear to have a limiting effect on EE. Continuous neuroleptic medication and low face to face contact (below 35 hours per week) have shown to be associated with reduced relapse rates in patients living with high EE families (Leff & Vaughn, 1985, in Vaughan et al., 1992). There is also some evidence that EE is a stronger predictor of relapse in males than females (Vaughn, Snyder, Freeman et al., 1984; Hogarty, 1985 in Vaughan et al., 1992) although most studies have a greater percentage of males in their sample which may explain part of this effect (Vaughan et al., 1992).

Thus, there is evidence which suggests that EE can influence relapse. This evidence comes principally from family intervention studies in which changes in the relatives's EE from high to low were associated with decreased relapse rates (Breslin, 1992; Hogarty et al., 1986; Tarrier et al., 1988;
Leff et al., 1989, in Vaughan et al., 1992). Further evidence that the relative's EE is not purely a consequence of the patient's behaviour or illness comes from a series of psychophysiological studies which demonstrated that the physiological reactions of the patient are influenced by the EE of their relative (Breslin, 1992; Turpin, Tarrier & Sturgeon, 1988; Tarrier & Turpin, 1991, in Vaughan et al., 1992).

Interestingly, in the Vaughan et al. (1992) study, it was found that the number of critical comments appeared to be one of the strongest predictors in relapse. Other EE variables, such as EOI and hostility did not significantly predict relapse. Rea et al. (1992) concluded that usually relatives are at a higher level of functioning and can incorporate the new skills at a faster rate than the patients. In turn, this change in the relatives appears to be necessary for subsequent change in the patient's interactional style, and a more positive course. If the relatives do not change, then it is unlikely the patient will change, resulting in a higher risk of relapse. This hypothesis is supported by the work of Doane, Goldstein and Miklowitz (1986, in Rea et al., 1991) indicating that parents whose affective style remained negative at three months tended to have schizophrenic offspring who were more likely to relapse.

During a patient's hospitalisation, s/he is removed from the community and his/her family, which serves as a respite for both of them. However, if interventions are made with the patient in
the hospital which are divorced from the problems s/he experiences at home, on discharge s/he will return to the family and community and the problems will still remain (Harris, Bergman & Greenwood, 1982, in Wittstock, 1989). In addition, hospital treatment is primarily medically oriented and limited to monitoring symptoms with medication. Drug maintenance alone is not useful in assisting the patient adjustment to family and community life or in providing skills necessary for employment (Kirk, 1977; Gillis et al., 1985, in Wittstock, 1989).

2.5.2 Community Services

Other explanations for the high relapse rate is that chronic mentally ill patients often do not receive even basic services in the community that were formerly provided by mental hospitals (Bachrach, 1975; Mechanic, 1986, in Rosenfield, 1991). These include the provision of physical services such as shelter and clothing as well as psychiatric treatment (Mechanic, 1987 in Rosenfield, 1991). Housing in particular is a critical problem for the mentally ill. Because social welfare benefits provide them with less than half of a poverty-level income, chronic patients often have access only to substandard housing (Boyer, 1987; Rossi & Wright, 1987, in Rosenfield, 1991). Direct evidence linking homelessness to rehospitalisation comes from research on aftercare patients. Homeless patients are significantly more likely to return to the hospital within 1 year.

Based on the arguments and evidence that homelessness contributes to relapse, Rosenfield (1991) expects that service interventions for housing would reduce rehospitalisation rates. This policy implication however, has not been tested empirically. Rosenfield (1991) concludes that rehospitalisation could result from the stress generated in living on the streets for an already vulnerable population, or from the greater visibility of mental health symptoms among homeless people, who are then more likely to come to the attention of authorities and be brought into treatment. It could also follow from intentional actions by patients or by staff on patients' behalf to gain shelter. It is possible that the lack of social connection associated with homelessness rather than the homelessness per se accounts for rehospitalisations. Further research is needed with larger samples on these possible reasons. But whatever the reasons, notes Rosenfield (1991), the findings imply that changes in housing policies are necessary to slow the revolving door syndrome.
2.5.3 Nonpsychiatric Forces

In a larger sense, at present, there seems to be a system of psychiatric care driven by nonpsychiatric forces (Rosenfield, 1991). Goodpastor and Hare's (1991) research supported this notion, wherein they found that the lack of a relationship between the time out of the hospital and diagnosis suggests that the principal issues may be psychosocial rather than clinical.

Harris et al. (1982) advocated that the role of the hospital "must be defined as a part of the overall treatment system rather than as an encapsulated, isolated experience in which both patients and community get a temporary respite from one another" (p. 227, in Wittstock, 1989).

2.6 New Trends in the Treatment of Psychiatric Patient's

"Erroneous beliefs and questionable scientific evidence have led over the past two decades to a loss of enthusiasm about psychotherapy with schizophrenic patients. Recent information from course and outcome studies and from new approaches to understanding schizophrenia provides a basis for renewed optimism. Improvements in psychotherapeutic technique have the potential to enhance effectiveness" (Wasylkenki, 1992, p. 123). Important new findings about schizophrenia and new approaches to psychotherapy with schizophrenic and mentally ill patients are discussed below.
Several new approaches have arisen from attempts to understand how psychosocial factors influence schizophrenia. Each of them has the potential to inform and enrich psychotherapy (Deikman & Whitaker, 1979; Rund, 1990; Wasylenki, 1992).

Relevant research has ascertained that psychosocial stressors may cause long-term changes in the manner in which the brain functions and that these changes may play a role in the development of mental disorders. Such stressors may also affect biochemical balances and other conditions in the brain, at least in predisposed persons (Barchas, Akil, Elliott, Holman & Watson, 1978; Askiskal, 1979; Kupfer, 1985 in Carson, Butcher & Coleman, 1988). Most investigators have been impressed with the high incidence of aversive life events that apparently have served as precipitating factors. The most frequently encountered precipitating circumstances can be noted as follows:

- loss-related events,
- employment problems,
- financial difficulties,
- death of a close relative,
- role loss,
- work overload,
- marital problems,
The vulnerability model of schizophrenia holds that the one feature all schizophrenic patients have in common is not the presence of illness but rather the presence of vulnerability (Zubin & Spring, 1977, in Wasylenki, 1992). Episodes of dysfunction are related to experiences of environmental stress. Breakdown of coping ability in response to stress and in the absence of social support causes vulnerability to evolve into disorder. It follows from this model that psychological interventions could be applied to restore coping ability, enhance social support, reduce the threatening nature of life events, or ameliorate chronic strain (Wasylenki, 1992).

Rund (1990) found that in the clinical settings where he had been working for the past 10 years, there had been great optimism regarding the possibilities of curing schizophrenia with intensive, long-term psychotherapy. Some scientific reports also support an optimistic point of view concerning the potential for psychotherapeutic treatment of schizophrenic patients (Karon & Vandenbos, 1981, in Rund, 1990). Generally speaking, Rund (1990) notes that positive results of such treatment have been difficult to prove in controlled effect studies.

On the basis of scepticism concerning the possibilities for schizophrenic patients to achieve full recovery, the following three questions were posed by Rund (1990) - which formed the basis of his research study:

(a) Do any schizophrenic patients fully recover?
If so, do they have anything in common as regards premorbid adjustment, history of treatment and hospitalisation, or any psychosocial conditions?

Is psychotherapeutic treatment an absolute precondition for full recovery?

Rund's (1990) study showed that some schizophrenics fully recover, but the percentage is low. He used the term "fully recovered", not "cured", because he believes that all (previous) schizophrenic patients have to live with a vulnerability for new psychotic episodes for the rest of their lives.

Concerning the second question - do schizophrenics who fully recover have anything in common? - Rund (1990) noted that it might be difficult to point out any specific factors that apply to all of them. However, he tried to postulate various forms of long-term recovery. For instance, in some of his cases, they all seemed to have a good premorbid psychosocial adjustment. This might in itself be one of the conditions for being able to profit from long-term, intensive psychotherapy. Their recovery seems primarily to have been organised around effective use of psychotherapy (Rund, 1990). Three of the ten patients in this study seemed to have organised their recovery around the development of and involvement with their current family. They all had a relatively poor premorbid adjustment and showed a clear schizophrenic symptom picture at an early period in life. One might presume that these patients are more vulnerable to future
psychotic episodes and that their spouses to a great extent serve as "anchors" for them (Rund, 1990).

Furthermore, eight of the ten patients in this study had been in psychotherapeutic treatment, which could be convincing evidence that psychotherapy is a valuable mode of treatment for some schizophrenic patients (Rund, 1990).

Wasylenki (1992) argues that the "nihilism of the past two decades with regard to psychotherapy for schizophrenia should be replaced by renewed interest and optimism. The decline in interest was based on faulty assumptions, and new information has emerged that supports a reconsideration of psychosocial approaches, including psychotherapy" (p. 126).

A more receptive, empathic listening mode, greater sensitivity to and understanding of the clinical relationship, a focus on stress management and social skills training can enhance our effectiveness as psychotherapists for schizophrenic patients.

It is important that psychotherapists work to help patients recognise the stress-inducing potential of relationships that are high in expressed emotion through cognitive and psychoeducational approaches as well as interpersonal learning (Silverstone & Romans-Clarkson 1989; Taylor & Perkins, 1991; Birchwood, 1992; Breslin, 1992; Wasylenki, 1992). Although drug therapy should be acknowledged as the basis of treatment for most schizophrenic
patients, drugs and psychotherapy should be used together to maximise the effects of each (Deikman & Whitaker, 1979; Wasylenki, 1992). Deikman and Whitaker (1979) further noted that excellent studies have been reported demonstrating that drug treatment may well be inferior to psychological approaches.

2.6.1 Medication Versus Psychosocial Treatment

Bockhoven and Solomon (1975, in Deikman & Whitaker, 1979) reported the results of comparing two five-year follow-up studies on hospitalised persons, one on patients receiving modern psychotropic medication and the other on patients treated in the absence of psychotropic drugs. The findings suggested that the "attitudes of personnel toward patients, the socio-environmental setting, and community helpfulness guided by citizen organisations may be more important in tipping the balance in favour of social recovery than are psychotropic drugs...Their extended use in aftercare may prolong the social dependency of many discharged patients" (p. 213).

Carpenter, McGlashan and Strauss (1977, in Deikman & Whitaker, 1979) showed a significantly superior outcome for acutely schizophrenic patients given psychosocial treatment and only sharply limited medication versus similar patients receiving the usual treatment emphasising drug therapy. Arieti (1974) furthermore stated, "In my experience psychotic depressions tend
to recur unless adequately treated with psychotherapy". And that "Drug therapy...in my experience is not sufficient in most cases to cure affective psychoses even from the manifest symptomatology" (in Deikman & Whitaker, 1979, p. 213).

Deikman and Whitaker (1979) point out that the "extreme reliance on drugs is wishful self-deception on the part of the psychiatric profession" (p. 213).

It is submitted that no one theory of mental disorders - neither the biological, genetic, cognitive, psychosocial nor personality characteristics - explain all the phenomena of a disorder. But each of them seems to have a piece of the truth and most important of all, these theories are not, by and large incompatible. They all play a role in accounting for the predisposition (Askisdal & McKinney, 1975, in Rosenhan & Seligman, 1989), and to a greater or lesser extent - to an 'etiological chain' that culminates into a mental disorder (Adams & Sutker, 1985). Thus, no single aspect should be ignored or treated exclusively in the treatment of mental disorders. This leads to the downfall of treatment, and no sooner than the patient is discharged from hospital, s/he returns.

The genetic and clinical variability within the diagnostic category of mental disorders, strongly suggests several causal mechanisms, with different factors varying in greater importance for different patients. It is only by learning more about
patients destined to become the subject of multiple readmissions, especially in the absence of psychotic illness, that more appropriate treatment can be designed and evaluated.

However, as we are now in only the "third year of the Decade of the Brain" (Breslin, 1992, p. 883), there is certainly room for optimism. An enhanced appreciation of the likely interaction of biological and environmental influences on mental disorders will arise from greater knowledge of neurobiology in both the healthy and diseased patients, and from a greater knowledge of molecular biology and of the use of drugs. It is hoped therefore that in the future patients will benefit from improved therapies (Breslin, 1992).

2.7 Conclusion

This chapter's aim was to focus upon both the international and South African research on readmissions. Close similarities were indicated and highlighted. Important treatment variables and new trends in the treatment of mental disorders were furthermore elaborated on.

Important issues associated with readmissions were raised from the literature. The focus of investigations into readmissions have been on psychiatric hospital treatment. Underlying problems connected to readmission of psychiatric patients have been
identified as follows:
- lack of family support and social networks;
- socio-economic factors;
- emotionally stressful family life;
- inadequate community service facilities.

The type of research done on investigating hospital treatment has been experimental. The following variables were focused upon; demographic data, clinical data, readmission data, clinical reasons for readmission, rehospitalisation patterns, and length of hospital stay.

From the literature, the salient factors underlying readmissions seem to be disconnectedness; absence of links between the patient and his/her family, the patient and his/her community, the hospital and family and the hospital and community.

A new holistic approach to the understanding of "pathology" and the treatment thereof, forms the subject of the next chapter.
3.1 Constructivism

The aim of this approach is to broaden our horizons and make us aware of our forever evolving ecology of ideas. It allows us to question our thoughts, perceptions and understanding of life. It emphasises that "reality" is not merely objective but rather the totality of our interpretations of what and how we perceive. Thus, it can be seen as an aid in "seeing" differently and providing new alternatives to understanding 'differences' and the treatment thereof.

The perspective that emphasises an "observer's participation in constructing what is observed is called 'constructivism'" (Keeney & Ross, 1992, p. 3). In a constructivist perspective all descriptions of "families and family therapy are seen primarily as information about the observer or community of observers. In other words, listening to what a family therapist claims s/he perceives in therapy tells us more, or at least as much about the therapist (the observer) as about the family (the observed). This shift in perspective, what the cybernetician Heinz von Foerster (1981b) calls the move from emphasising observed systems
to emphasising observing systems, is our starting point" (Keeney & Ross, 1992, pp. 3-4).

This "newer" thinking does not refute what has gone before: we cannot state that Newtonian physics is "wrong" and the systems view is "right". As Capra (1985) points out, it has come to be realised that any type of thinking is merely an approximation to reality and no theory or model is able to give a "complete and final account of natural phenomena" (p. 93). The understanding that there is no absolute truth was slowly accepted and brought into focus. With this belief the question "what is the truth" began to be explored.

What gave rise to this new way of understanding and thinking about "reality" was the research into neural nets by von Foerster and experiments on the colour vision of the frog by Maturana. These indicated that the brain does not process images of the world the way a camera does, but rather, computes them like music on compact discs. It would therefore be impossible, to know what the image was "really like" before it was transmuted by the brain (Hoffman, 1990). Bateson also played an active role in spearheading the ideological origins of the thinking which challenged the absolute truth of a situation. In his book Mind and Nature: a Necessary Unity (1979) he emphasised the need for one to take cognisance of many views on a particular subject. It is only when one pays respect to these multiple views that one can really gain an effective
understanding of the sense of what is being observed. Reality therefore seems to be an almost instinctive sense of what things are and how they work.

A remarkable characteristic of constructivistic epistemology is that it encompasses theories and theorists from very different areas (physics, biology, philosophy of science, cybernetics, ... and psychology). Furthermore, some scientists of these disciplines (eg., Maturana, Varela, von Foerster) have been exchanging experiences and thoughts with family therapists. Such a dramatic interdisciplinary exchange, it has been suggested, is a phenomenon with few antecedents in the history of psychotherapy. However, in spite of their common constructivistic position, not all of these theorists and practitioners agree in their interpretation and elaboration of constructivism (Feixas, 1990).

An essential characteristic of constructivism must include the awareness that each individual is an active constructor and inventor of his or her pictures of the world and of him/herself. According to Efran, Lukens and Lukens (1988) good constructivists "acknowledge the active role they play in creating a view of the world and interpreting observations in terms of it" (p. 28).

Psychologist George Kelly, who introduced personal construct theory, is considered by many as the first person formally to bring a constructivist perspective to the fields of personality
theory and mental health. He insists that we are not to confuse our inventions with discoveries (in Efran et al., 1988). Watzlawick (1984) supports this notion and notes that objectivists are inventors who think they are discoverers, i.e., they do not recognise their own inventions when they come across them. Good constructivists, on the other hand, acknowledge the active role they play in creating a view of the world and interpreting observations in terms of it (Efran et al., 1988). As Kelly (1969) notes:

"I must make this clear at the outset. I did not find this theory lurking among the data of an experiment, nor was it disclosed to me on a mountain top, nor in a laboratory. I have, in my own clumsy way, been making it up" (in Efran et al., 1988, p. 33).

The heart of constructivism is the recognition that our hypotheses about the world are not directly provable. To the constructivist, scientific hypotheses persist mainly for two reasons, "neither one having much to do with objective truth: first, because we find them useful in our work (utility); second, because no one has yet been able to either disprove them or come up with a better alternative. Hypotheses that persist are, at best, part of a temporarily acceptable working framework" (Efran et al., 1988, p. 28). Thus, the main assertion of constructivism is that "reality cannot be revealed to us in only one true way. Instead, we come to know reality through our
process of construing: we invent reality rather than discover it" (Feixas, 1990, p. 5).

This conception of reality is closely linked to Bateson's belief that the world which we create is made from our presuppositions, premises and expectations. We all wear particular pairs of spectacles or lenses which provide us with a particular way of seeing the world. Efran et al. (1988) believe "it is useful to have the freedom to change 'lenses' from time to time" - they refer to changing lenses particularly in terms of the choice of the level of analysis at which one will want to focus at any given time (p. 30). For example, in psychotherapy one could focus on the individual, couple, family, extended family, community and so on. Looking through each of these different lenses opens up new alternatives and options for intervention into the system.

As Kuhn says the spectacle lenses or paradigm chosen introduces "a class of facts...shown to be particularly revealing of the nature of things" (in Fishman & Rosman, 1986, p. 4). These visions which we therefore have provide us with our sense of how the world works. According to Sowell (1987) our visions are indispensable but he cautions us that they are also dangerous, "precisely to the extent that we confuse them with reality itself" (p. 14). He reports that we all have different ways of conceiving human nature and the world and very often these views lead to sharply divergent conclusions on major issues. A
conflict of visions can arise and for a conflict to be resolved it requires a change of spectacles of all parties concerned.

3.1.1 Context and Meaning

Another critical characteristic of constructivist thinking, which fits reasonably well with what many of us do, is the constructivist emphasis on context and meaning. For the constructivist, "everything said is said from a tradition," (Varela, 1979) and has meaning only within that tradition. Take something out of context and it becomes meaningless. Put it in a new context, and it means something else. Problems - "mental or otherwise - are not circumstances or actions taken in isolation. They are ascriptions of meaning that arise within a particular tradition" (Efran et al., 1988, p. 28) - it is a framework of activity and interpretation, made possible by the shared language system in which we all operate.

Language is the one essential that such complex co-ordinations of action in a social community cannot do without, and that is why constructivists insist on talking about human lives as basically being "conversations". Constructivist therapy then, is "figuratively and literally, a specialised form of conversation" (Efran et al., 1988, p. 32).

The Milan original team, represented by Selvini-Palazzoli, Boscolo, Cecchin and Prata, points out that our linguistic habits
tend to orient us to think in lineal, possessive terms rather than circular, reciprocal ones. The team credits Shands (1971) for drawing attention to this "tyranny of linguistic conditioning" (in Tomm, 1984, p. 119). However, the team discovered that if it was careful to substitute the verb "to show" for the verb "to be" it was easier for it to maintain a relational or circular orientation when describing a component part of a larger system. For instance, as the team points out, one could make the statement that the "father is depressed" or that the "father shows depression". If one employs the former, one implicitly separates the father from his context and becomes oriented towards looking inside him for the basis of the depression. One might look for psychodynamic factors in superego functioning or for some biochemical abnormality in his nervous system. On the other hand, if one describes him by saying the "father shows depression," one tends to wonder to whom is he showing this depressive behaviour and what effect this might be having. Thus, one becomes inclined to examine what is happening in the father's context (in his relationships), to explain why he shows this "difference" in his behaviour. This technique of verb substitution it is submitted, is a very simple, yet useful, exercise for trainees who are trying to learn to think within the framework of a circular epistemology (Tomm, 1984).

Unfortunately, written and spoken language cannot escape from the problem of lineality. Words follow in sequence. The grammatical presentation of sentences into subject, verb and object makes us
think in lineal sequences. On the other hand, the connotative function of language does make it possible to create a semblance of circularity. This is evident in the ability of language to evoke images and patterns through the use of metaphors, similes, analogies and stories. Nevertheless, the most important tool in therapy, language, should always be regarded with some degree of suspicion since it is also a major source of distortion and constraint (Tomm, 1984).

The aim of therapy and the understanding of human behaviour should be an ever evolving process, forming new ecologies of ideas, as systems are continuously changing. If we as therapists are not aware of this, we could use "economics of flexibility" (Bogdan, 1984). What this refers to is the phenomenon whereby any frequently used idea becomes an unconscious habit of sorts. We develop the habit of not examining our most frequently used generalisations each time we use them.

Constructivists argue that none of our ideas about our clients' problems are objectively true in the sense of describing how things really are; "however, most therapists still feel that at least some of their ideas have objective validity. We might, perhaps, when discussing philosophy with our colleagues readily agree that there is no one way of looking at things, but when it comes to our own beliefs about particular clients, we tend to cling tenaciously to our own truth" (Efran et al., 1988, p. 30).
It is the essence of constructivism that we tend to forget that ideas arise in the minds of observers and are not the reality of the situation. The researcher must ask how one can believe that s/he knows, when in fact all that the observer can do is to attempt to imagine, understand, think or accept as a matter of belief the reality in question. As already noted, we are not discoverers - we are inventors.

Constructivists suggest that this self delusion (i.e., the belief that we know) leads to the problem that most psychological attributions and explanations of behaviour cannot be objectively disproved. Indeed in attempting to dispute these explanations one is really accepting the proof of their validity (Efran et al., 1988).

For constructivists, the entire therapeutic venture is fundamentally an exercise in ethics. It involves the inventing, shaping, and reformulating of codes for living together. In other words, "from this point of view, therapy is a dialogue about the interlocking wants, desires, and expectations of all the participants, including the therapist" (Efran et al., 1988, p. 32). It is a theory of knowledge - not a collection of therapeutic directives or techniques. However, if adopted, it places certain restrictions on how therapy is to be construed. For example, it clarifies how important it is for both therapists and clients to accept full responsibility for the consequences of
their association with one another, even though those consequences are not entirely predictable at the outset (Efran et al., 1988). What is furthermore important, is the organisation of ideas in the minds of certain persons in order to bring about change.

This way of understanding and viewing "reality", allows effective operations of all the psychotherapies to be explained within this framework. In other words, constructivist therapy is not a specific school of therapy: it is a term which refers to the activities of therapists who work within the domain of cybernetics and ecosystemic thinking. There exists many differences amongst such therapists but, as Tomm and Lanamann (1988) point out, they all hold the core belief that one cannot diagnose some objective condition and one cannot deny the influence of the clinician's subjectivity.

3.2 Systems View of Process

According to Buckley (1967, in Duncan, Parks and Rusk, 1990), systems may be classified at three levels, each applicable to a specific domain, i.e., "mechanical/equilibrial (inorganic, chemical, and mechanical systems), organismic/homeostatic (biological systems) and process/adaptive (social systems). At the process/adaptive level, process is primary; structure, which is fluid and ever changing, is created through the actions and interactions of system members and their continuously developing
relationships. Structure is but a temporary, accommodating representation of an ongoing process" (Duncan et al., 1990, p. 568).

Inherent to process level systems is a capacity for evolution and elaboration; these systems are not only sensitive to change (variation), but are essentially dependent on change to remain viable. "Individual and shared meanings constructed through the interaction surrounding the variation both guide and are shaped by the ongoing interactional process. Variation stimulates the interactional process, construction of meaning, and the continual movement toward greater complexity, flexibility, and differentiation (Duncan et al., 1990, p. 569).

Buckley's process view of systems provides a flexible theory base for technical eclecticism (Fraser, 1986, in Duncan et al., 1990). "The emphasis on the interactional process surrounding variation and its importance to the meaning, construction and growth of the system, can be applied to the process of psychotherapy. The therapist offers variation through conversation and behavioural prescriptions. Both avenues of variation stimulate interactive process and meaning construction, thereby effecting change and client growth" (Duncan et al., 1990, pp. 569-570).
With this holistic framework and understanding - we are provided with a conceptualisation when working with systems, problems and issues. Various models/paradigms for treatment can be used within this framework. A constructivist and process oriented perspective may provide a framework for the selection of interventions matched to the client's world-view and goals.

For our purposes, one specific paradigm will be elaborated on - the ecosystemic paradigm, and illustrated practically with a case example. Within this paradigm, various other strategies and techniques will be employed from other models, as there is a close overlapping of paradigms/schools of thought. This will lead us to strategic eclecticism in our workings and treatment.

While strategic eclecticism offers freedom in choosing intervention options, it also imposes on the therapist a responsibility to broaden content and procedural repertoires, since no one or two theories are seen as sufficient to explain and effectively address the diversity of presentations clinicians routinely encounter (Duncan et al., 1990).

What is important is the flexibility of the treatment employed, so as to fit with the system. It is hoped that these ideas will stimulate continued dialogue among eclectic practitioners who recognise and value the contributions and theoretical realities
of multiple, diverse approaches (Duncan et al., 1990).

This conceptual understanding provides us with a framework from which to work. Furthermore, from this understanding our epistemology can begin to emerge.

Auerswald (1985, p.1) refers to epistemology as a "set of imminent rules used in thought by large groups of people to define reality" - in other words, "thinking about our thinking". According to its intrinsic nature, epistemology cannot be avoided by any theoretical approach to human understanding. Every theory evolves from an epistemological position which includes a set of assumptions about the human possibility of knowing the world (Feixas, 1990).

3.3 Ecosystemic Paradigm

Ecosystemic paradigm was chosen as the model for the investigation of readmissions. This epistemology recognises that truth is relative and thus attempts to expand the universe of the researcher to combine his/her reality and that of the patient into the widest possible view of reality. It also recognises that reality is generally socially constructed and thus searches for patterns of relationship which connect all living things as a way of constructing reality. The contexts in which the patterns
occur, fix the meanings and are thus considered an important part of reality. The researcher and patient together interact to form the process of research. Ecosystemic research can be summarised as participant observer research with both researcher and patient having unique views of reality which can be combined to give a view of views or a metaview of reality (Wittstock, 1989).

Readmissions can be seen as an important part of the family's attempt at maintaining its interaction patterns. While in the hospital the patient is removed from the family and its interactions and recovers. On return to the family, the interaction patterns continue as before and the symptoms may recur.

Ecosystemic epistemology provides a theory from which communication patterns could be explored which link symptom, patient, family and community as well as hospital and community.

Various important concepts of this paradigm are discussed below. Illustrations and examples of how these concepts are used within the therapeutic context will follow in the case study.

3.3.1 Punctuation

Basic to understanding epistemology is the idea that what one knows and perceives is largely due to the distinctions one draws. Each person develops his/her own world-view or epistemology which
According to Keeney is based on the distinctions s/he observes.

According to Keeney (1983) the most basic act of epistemology is the creation of a difference. It is only by distinguishing one pattern from another that one is able to know our world. However, it is noted that the distinction is not real in itself, rather it provides us with a description to describe what we observe. There is thus a recursive process in that "we draw distinctions to observe and subsequently we draw distinctions in order to describe what we observe" (Keeney, 1983, p. 24).

An infinite number of distinctions can be drawn for any situation. Varela (1979) states that drawing distinctions enables us to create "physical boundaries, functional groupings, conceptual categorisation, and so on, in an infinitely variegated museum of possible distinctions" (in Keeney, 1983, p. 20).

When an observer draws a distinction s/he concomitantly makes an artificial break into a sequence of events (Keeney, 1983). We therefore each develop our own epistemology or world-view which is based on the distinctions we observe. How we make these distinctions and thereby attribute meaning to events is what Keeney (1983) calls our "punctuation" (p. 25).

When an individual or family enters a therapist's office with established habits of punctuation, the therapist must have a "way
of punctuating their punctuation (or an epistemology about their epistemology)" (Keeney, 1983, p. 27). Thus, punctuation is basic to an understanding of epistemology and refers to how sensory-based experiences are organised so that a pattern or sense can be seen therein. From this organisation or punctuation our epistemology can be identified (Keeney, 1983).

3.3.1.1 Linear Punctuation Effects

This belief in clinician subjectivity is a paradigmatic shift away from a strictly Newtonian linear cause-effect punctuation for psychotherapy. The Newtonian punctuation is "extremely deterministic in nature and implies the existence of rigid and static concepts. If a therapist should view a person categorised as "schizophrenic" from this linear punctuation, a search for a cause would be made and, once the cause is found, a suitable treatment, often pharmacological, will be initiated to eliminate, control or stabilise the suspected cause. Symptoms are treated and when treatment results are not effective alternatives related to the perceived cause of illness are sought" (van der Velde, 1989, p. 55).

The therapist who follows this linear epistemology categorises the individual in terms of the individual's observable behaviour and reported words, and hypothesises about causal connections. If the therapist notes that "the individual shows unusual
perceptions of reality it may be suspected that the individual could be a "schizophrenic". Further research for symptoms such as auditory hallucinations and bizarre speech patterns and ideas may serve to confirm the hypothesis that this individual can be placed in a functional grouping of disorganised, paranoid or other schizophrenias" (van der Velde, 1989, pp. 55-56). The placing of the individual into this "conceptual category" (Keeney, 1983, p. 20) of schizophrenia results in the therapist analytically and logically selecting an appropriate treatment of therapeutic intervention (van der Velde, 1989).

Keeney believes that this form of punctuation is extremely simplified. The "schizophrenic" is "isolated from the whole process: his/her expectations, feelings and attitudes towards the situation are clearly not within the diagnostic boundary and are therefore not a necessary part of the diagnosis. What in fact has happened is that schizophrenia has been regarded as a material thing, i.e., the concept has been reified and the person has been neatly slotted into the appropriate category" (van der Velde, 1989, p. 56).

The traditional linear thinking has conceptualised the situation in terms of a "created abstraction about that experience" (Keeney, 1983, p. 45). "Therapists who are concerned with understanding the discrete elements of a situation work within an atomistic framework. They ignore their role as a participating observer in the situation and distance themselves from the
patient" (van der Velde, 1989, p. 57). The patient becomes anonymous, a mere category and even in relation to the diagnostician "tends to disappear behind the symptoms, as if these had independent existence" (Watzlawick & Weakland, 1977, p. 177). In fact what happens is that the symptoms become more real than the patients themselves (van der Velde, 1989).

The predominant mode of thinking and knowing in Western Cultures tends to be this lineal epistemology. That is, most Westerners automatically tend to apply reductionistic habits (of thought) and "punctuate" reality by dividing interaction process into small segments (Tomm, 1984, p. 118). The treatment process becomes a simplistic search for a linear cause and effect syndrome.

3.3.1.2 Constructivist Punctuations

The Newtonian world-view is anticontextual and is in sharp contrast to the constructivist thinking which states that therapists will only be able to "understand their clients if they observe how the client's social context is punctuated" (Keeney, 1983, p. 27). Therapists who focus on the broader context that is always part of any behaviour are attempting to work with descriptions of pattern rather than material descriptions and are working with the concepts utilised within the ecosystemic and cybernetic paradigms (van der Velde, 1989).
Such a view suggests that therapists attempt to gain an understanding of their client's personal epistemology, i.e., how they "acquire this particular way of knowing the world" (Keeney, 1983, p. 27). According to Keeney and Silverstein (1986) the (ecosystemic) therapist must utilise the client's communications as a means of "building a way of knowing and influencing higher order patterns of systemic organisation" (p. 12). A circular epistemology orients the observer to focus on recursiveness in the interaction between parts of the system and to hypothesise about holistic patterns (Tomm, 1984).

In order to understand mental events as a circular process, a deliberate attempt must be made to synthesise behavioural connections into larger, holistic patterns. Fractionated sequences are recombined into a fully circular totality or whole. When employing a circular orientation, the observer might "discover" that when the husband becomes angry the child misbehaves, when the child misbehaves the wife is critical, when the wife is critical the husband becomes angry, etc. Then one could conclude: "The husband shows anger as part of a recursive pattern of interaction between the wife, husband and child. What a vicious pattern!" (Tomm, 1984, p. 118). Here the judging process is directed towards the whole cycle of behaviour - not towards the behaviour of any one member involved in that cycle. The situation, when regarded as one in which the participants are "caught" in a recursive pattern, becomes more like a misfortune,
calling for compassion for the persons involved rather than condemnation. As a result, the attitude of the therapist differs. When able to achieve and hold a circular epistemology, s/he is much less moralistic. The therapist becomes more neutral, which in turn allows the family more freedom to explore alternatives for change. Insofar as the therapist is able to achieve a systemic stance, s/he also becomes liberated to be more creative as well (Tomm, 1984).

It is believed necessary for therapists to come to know how patients view the enmeshment of their internal and external reality. This, Keeney says, is a "higher order epistemology which is essentially an epistemology about how others come to punctuate and know their world" (in van der Velde, 1989, p. 58).

"Reality is no longer reified, i.e., merely a thing, but is something which is part of an unbroken flow and totality of being" (van der Velde, 1989, p. 58).

The newer thinking emphasises that it must be taken into account by therapists that they themselves are playing a role in the experiential world which is being observed, i.e., they are always "participating in the construction of a world of experience" (Keeney, 1983, p. 152).

Korzybski's (1941) comments regarding "the map not being the territory" suggest that each therapist's theory is only a map
which enables him/her to understand the situations encountered (in van der Velde, 1989, p. 53). "The therapy in which the therapist believes varies according to how the therapist conceives the so-called problem situation. For example, in considering "schizophrenia", treatment will differ depending on whether schizophrenia is viewed as physiological, interactional or psychodynamic in origin and nature. These different conceptions will also determine differences in prognosis, evaluation of results and treatment" (Fisch, Weakland & Segal, 1982, in van der Velde, 1989, p. 54). Therapists create "maps or models of the world which they rely on as a guide for behaviour. All such maps are created by systems of description and there are as many descriptions as there are ways of drawing distinctions" (van der Velde, 1989, p. 54).

The Milan team opposes an either/or dichotomy of lineal versus circular epistemologies. Instead, it sees a part/whole relation between them. Lineal thinking may be a necessary precursor to the discontinuous jump to circular thinking. Furthermore, a lineal punctuation is not necessarily wrong. However, it is often misleading because it describes only a segment or small arc in a larger circuit. The circular perspective is assumed to provide a more complete and coherent view (Tomm, 1984).
3.4 Understanding Change

In adopting a systemic perspective, the capacity to shift from a reductionistic to a holistic orientation is essential. This entails a shift away from evaluating the intentions of family members to evaluating the "effect" of their behaviour. Then one evaluates the effects of that effect, etc. The focus is always on identifying circular patterns that are characteristic of cybernetic feedback. This approach includes the assumption that the therapist is also part of the pattern that s/he is observing. Thus, there is a circular pattern between the therapist and the circular patterns s/he is exploring in the family. This process has been described as the cybernetics of cybernetics or second order cybernetics (Keeney, 1983) and more accurately reflects the complexity of the epistemology proposed by Bateson.

The Milan team assumes that the family's patterns of behaviour evolve through trial and error. If a certain action fits the occasion and is "successful", it tends to be repeated in similar circumstances. When the behaviour and the circumstance become "coupled", a pattern becomes established. Subsequently the participants in the situation may construct a "social reality" to describe and explain the pattern which has evolved. This "construction of reality" takes place through the process of communicative interaction between the members of the system (Pearce & Cronen, 1980, in Tomm, 1984, p. 120).
Consensual "meanings" are assigned to specific behaviours and events, and to the patterns that connect them. Once created, this reality becomes the map which channels family members' actions along redundant patterns. That is, initially patterns of action lead to the generation of maps and subsequently these maps guide patterns of action. Thus, there is an important "reflexive relationship between meaning and action, between the map and the territory. Interpersonal patterns of action influence family beliefs and these beliefs in turn influence patterns of action. A change at one level triggers change at the other and vice versa" (Tomm, 1984, p. 120).

However, this is not always the case. A change in behaviour may not necessarily result in a change in beliefs and change in beliefs may not result in a change in behaviour. Despite the reflexivity between meaning and action there is probably never an isomorphic relationship or perfect fit between the two. Whereas behaviour reflects a dynamic process that varies continuously, a map, once outlined, is static. When patterns of behaviour continue to evolve while the associated cognitive maps remain the same, the discrepancy between them widens. At a certain point an effort may be applied to narrow the gap. Usually the map is eventually modified to fit the changes in behaviour patterns, but in the interim an effort may be made to try to get the behaviour to conform to the map. This latter tendency for "old" beliefs to channel present behaviours into "old" redundant patterns leaves the family appearing "stuck" when their continuing behavioural
evolution has taken them past the point where a particular map fits. However, the system never stops evolving (Tomm, 1984).

Further behavioural changes take place around the point of apparent non-progression to accommodate to the constraining belief as the family continues to evolve. With increasing retention of outmoded maps over time, the degree of discrepancy, distortion and constraint grows until the system becomes increasingly "symptomatic" (Tomm, 1984, p. 120).

3.5 The Construction of Therapeutic Realities (Keeney, 1987)

It is submitted that the construction of the therapeutic reality can be depicted in terms of the management of "semantics" and "politics" (Keeney, 1987). Semantics is used here as the "name of a communicational frame of reference wherein meanings are requested and constructed" (Keeney, 1987, p. 469). In other words, meaning is requested and constructed by the therapist and client. Politics, on the other hand, is used as the "name of a communicational frame of reference that principally attends to the specification of 'who-is-doing-what-to-whom-when-where-and-how'" (Keeney, 1987, p. 469). Any construction of meaning always implies political consequences and any specification of politics carries with it particular meanings. Semantics and politics are two sides of the same conceptual coin: they suggest two different ways of viewing human communication. Stated

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differently, human communication may be viewed through a semantic frame of reference that emphasises meanings, or a political frame of reference that emphasises the social/cybernetic organisation of communication (Keeney, 1987).

The distinction between "political and semantic frames of reference provides us with a view of the basic building blocks that are used in constructing therapeutic realities" (Keeney, 1987, p. 469). Keeney and Ross (1992) note that it is important that the various systemic family therapies must follow patterns of interwoven political and semantic frames to construct therapeutic realities. They quote a story by Bateson where the interrelationship between the semantic and political frames of reference were ignored and the adverse results flowing therefrom - which is described in the following illustration:

At a conference he attended, a Dutch psychiatrist, lecturing on schizophrenia, announced that 'the schizophrenic mind is disordered'. As an example, he described a psychiatrist asking his institutionalised patient what the difference is between a ladder and a staircase. The patient responded, 'A stocking' - his evidence for a 'disordered mind'. Bateson asked the psychiatrist to give another word for a run in a woman's hose. The psychiatrist eventually responded, 'Ladder'. 'You see', Bateson added, 'the patient could be commenting on the sexual difference between herself and the doctor'. (in Keeney & Ross, 1992, p. 8)
If one examines this scenario in terms of semantic and political frames of reference, the question regarding the difference between a ladder and a staircase can be seen as more than a request for meaning. It is according to Keeney and Ross (1992) a communication taking place in the political context of a therapist and client relationship within a hospital. They explain it as follows:

The 'patient' knows that the 'therapist' is supposed to have expertise in helping her. In this political context, it is odd that the therapist asks questions to which the patient and doctor must know the correct semantic answer. The doctor, in fact, is not interested in the semantics of his question but is pointing to a political frame of reference: the doctor wants to prove a difference between himself and the patient. This difference, of course, organises the politics of mental hospitals: the doctors and patients must repeatedly prove that they are different. In effect, a semantic frame is enclosed within a political frame. The so-called crazy message given by the schizophrenic is therefore a transform of the way the therapist packaged his question. By responding 'stocking', the patient uses metaphor to conceal her response about politics in the same way that the doctor had concealed his request about politics. (pp. 8-9)
This illustration emphasises the importance that all systemic family therapies must involve semantic meaning coupled to the political patterns that organise social interaction.

3.6 Systemic View on Health and Pathology - A Strategic Eclecticism

The most critical problems in the field of psychopathology today are conceptual in nature. The ways we choose to conceptualize a disorder guides our thinking and sets the limits on possible insights regarding its etiology, classification, and treatment (Marsella, 1984).

With this systemic viewpoint the idea of "pathology" has somewhat evolved, being a dramatic shift in the understanding of "pathology". This shift has in turn effected our perception of diagnoses and treatment. As noted, linear causality was the underlying rationale of the medical model. "Pathology" was treated as an independent entity - that could be objectively observed and treated/manipulated. "Pathology" was seen as having been caused by internal and/or external factors. With this notion, and viewing "pathology" as an "independent entity" (localised in the individual) - the observer and the context were not taken into account.
Haley (1980) points out that if the therapists assumption is based on the belief that there is a physical cause for the psychosis, then it will inevitably give rise to the following:

(a) institutionalisation;
(b) reliance on medication;
(c) a tendency to see the individual as responding in an inappropriate and maladaptive manner to his family; and
(d) a tendency to view the individual as being mentally defective.

Thus the primary issue will always remain a diagnostic one. Once a label/diagnosis such as schizophrenia has been given, the individual has little chance of ever being viewed as becoming healthy again (Haley, 1980).

The systemic approach that evolved - resulted in drastic changes in one's way of viewing and dealing with the problem situation. This approach based upon the cybernetic theory, conceptualised behaviour as having a homeostatic nature, and that it is a reaction to current, present situations. According to systems theory, any attempt to change the system is likely to result in the system stabilising itself (Haley, 1980; Keeney, 1983). The system is seen to use feedback processes to maintain itself.
The major advantage of systems theory is that it allows repetitive behaviour to be seen, and therefore predictions about behaviour to be made. Therapy can be planned on the basis of this.

However, the major disadvantages of this theory, according to Haley (1980) are as follows:

(a) This theory is more a theory of stability than it is of change.

(b) It is sometimes difficult to simplify repetitive sequences of behaviour in such a way that the members of the system can also see and use them.

(c) Because of this, this theory is not always sufficient for family therapy where an attempt is being made to change a family.

(d) It is inclined to see all the participants as equal forces - a fact which does not hold true for all families.

(e) Systems theory also tends to prevent any one particular person in the family system from having to take responsibility for something.

3.7 Health and Pathology as mere Punctuations

The classification of certain actions, patterns, or systems as "pathological" or "healthy" is in contradiction with an epistemology which strives to transcend polarities (Keeney, 1983).
The Rosenhan-studies (Rosenhan, 1973; Rosenhan, 1979, in Joubert, 1987) clearly showed how psychiatric personnel found psychiatric disturbances in completely healthy pseudo-patients, when the context and their presuppositions required them to find pathology. After such a diagnosis had been made further information is punctuated, in terms of the diagnosis!

Such a diagnosis has a paralysing effect on both patient and therapist. Andolfi (1979) states that the therapist will inevitably experience the same feelings of helplessness as the patient and family, if he accepts the "context of madness"; and that his/her interventions will be ineffective.

Foudraine in his book, Wie is van hout, refers to Sullivan who tried to rehabilitate deteriorated patients in a chronic section of a psychiatric hospital. His first step was to change the context of pathology to a context of learning. The words 'section', 'nurse' and 'patient' were changed to 'instructional centrum', 'instructresses', and 'student'. After initial difficulty, this contextual shift had a marked influence on both personnel and patients (Foudraine, 1971, in Joubert, 1987).

Within this conceptualisation, "pathology" and "health" are, only punctuations that are used by an observer, and the reification of such concepts are epistemologically and philosophically untenable within an ecosystemic model (Keeney, 1983).
However, to say that "pathology" does not exist, and then going forth and treating systems for problems, represents a contradiction.

Cybernetics attempts to transcend this contradiction by fusing the dichotomy pathology/health into a single concept. Conversely cybernetic epistemology looks for patterns in systems, rather than pathology (Keeney, 1983). Cybernetics searches for patterns of feedback which are embedded in or are secondary to greater patterns or higher-orders of feedback (calibration). Within feedback cycles incorrect feedback can be identified, according to the cybernetic model (Keeney, 1983).

Haley (1980) specifically narrows down his choice of which "disturbed" people he sees as benefiting his style of therapy and as fitting his theory. Specifically he focuses on the age group of "leaving home". He states that such people encounter problems due to their families being unstable at that point. He stresses that the therapist should view such a young person as performing positively and adaptively to a maladaptive social situation. Thus, one should believe that the young person involved actually has the potential to be "normal".

Haley (1980) maintains that the goal of therapy should always be uppermost in the therapist's mind. The therapist strives to maximise a person's potential. He further submits that
eccentric, handicapped behaviour has a family function - it is a response to strange communication in the system.

Haley (1980) further explains that problematic behaviour in young people is essentially representative of the current basic organisational structure in the family. Thus, the social situation must be viewed. He argues that the incidence of behaviour problems is usually at it's highest when a family member is about to leave home. The time of greatest change is experienced when there is about to be a change in the constituents of the group membership. It is argued that the individual's success outside of the home reverberates back to the family he has just left; the old system has to reorganise itself in terms of hierarchies and new styles of communication. Problematic behaviour in individuals in their late teens or early twenties, should be seen as a warning that the organisation is malfunctioning and thus preventing the person from leaving home - for example:

In single parent families, the departure of a child may leave only the parent and this may be an unacceptable position for the lonely parent.

In two-parent families, the parents face a return from a multi-person organisation to a two person organisation. It is possible that previous communication was done through the child, and that the departure of the child brings a new difficulty for the parents in communicating. This may lead
to the parents possibly threatening divorce or showing some other symptom.

Thus, the problem seen in some families is often a response to threatened organisational change. Such families often reason that the problem will be resolved if the child/member were to remain at home. Contrary to this, the person finds him/herself being constantly exposed to pressure both from the community and physiologically, to leave home and become independent. The member becomes caught in a double-bind and conflictual situation. What can be done about this? One hypothesis is that if the young person develops a problem that makes him a "failure", he will have to remain at home, and the old family system is thus stabilised again. The communication pathways and the organisation remain the same. When failure to disengage has once succeeded, the "problem" can be used indefinitely to maintain the old system. There are indeed two major ways through which a family can stabilise:

1. Via institutionalisation and/or medication, which prevents the young person from becoming independent.

2. Via the young person becoming a "failure". If he is defined as a failure he is still dependent on the old family system to look after him. Even if the young person is a "failure" outside of the home, this failure serves the same purpose, as the family system can still communicate about the individual or through the individual.
Haley (1980) explains that the solution to such problems lies in the fact that change occurs most rapidly in a community setting, in which the individual concerned is forced/required to engage in "normal" activities.

This approach thus argues that diagnosis must be reframed in order to avoid the 'diagnostic impasse' that grips therapists who identify diagnosis with the psychiatric medical model. An attempt is made to place diagnosis within the paradigm represented by the ideas of cybernetics, ecology, and systems theory. This approach aims to attune itself to interrelation, complexity, and context (Keeney, 1979).

3.8 The Symptom's Presence in the System

An important diagnostic issue which surrounds this approach - concerns how therapists view 'symptoms'. Some therapists have stimulated controversy in disregarding the intrapersonal views of symptoms by relabelling symptoms as interpersonal strategies (Watzlawick et al., 1974). Haley (1963), for example, describes symptoms as "communicative acts that have a function within an interpersonal network" (p. 99). However, one's view of a symptom is contingent upon one's chosen frame of reference. Symptoms can also be seen as "communicative acts that have a function within intrapersonal and interpersonal systems" (Keeney & Cromwell, 1977, p. 232). In other words, since symptoms are multi-systemic phenomena (i.e., communication involving diverse
system levels), it follows that there are various perspectives from which to approach symptoms. Accordingly, the multi-systemic character of symptoms means that both intrapersonal and interpersonal framings are potentially viable (Keeney & Cromwell, 1977).

Systemic diagnosis as a strategy attempts to maintain access to both intra- and inter-systemic viewpoints of symptoms. This approach is facilitated by dealing with such issues as:
(a) where/how symptoms are manifest and
(b) where/how symptoms are perpetuated or maintained.

Systemic diagnosis thus assesses the symptom by identifying the context or system level where it is most manifest, and the systemic homeostatic processes which maintain the symptom by scanning diverse system levels (Keeney & Cromwell, 1977).

Therefore, a major contribution of this approach has been the observation that symptoms are inextricably interwoven as part of a relationship system and that accordingly the site and nature of symptom manifestation may shift (Keeney, 1979). Generalisations that have been made include:
(a) Difficulties in any part of the relationship system may give rise to symptomatic expression in other parts of the system.
(b) Symptomatic relief at one part of the system may result in a transfer of symptomatic expression to another site.
Significant change, eg., second-order change as Watzlawick et al. (1974) call it, in any part of the system may result in change in other parts of the system—what Speck (1973) has called "ripple effects" (in Keeney, 1979, p. 120).

These principles suggest that symptoms be viewed as relationship metaphors—communications about relationship (Keeney, 1979). The major implication for the therapist is that s/he should look for the communicative function of symptoms within an ecological relationship system. When a symptom is viewed as a communicative function, it becomes an indicator or sign for the ecology of relationships (Keeney, 1979).

3.9 The Therapists’ Role in Understanding and Dealing with Symptoms

The cybernetic network representing a family system (not individuals within a family but rather patterns of relationship) includes governing loops or circuits that keep the system in check. These governing loops help to maintain family stability and have accordingly been called "homeostatic cycles" (Hoffman, 1976). When the homeostatic cycle serves to prevent a necessary change (eg., during developmental transitions), the family members can be seen as experiencing a problem.
According to Hoffman (1976), this type of homeostatic cycle is what family therapists attempt to disrupt. She notes that "when experienced family therapists find this cycle, they direct an intervention toward it with the precision of a laser beam" (p. 502). This homeostatic cycle is seen as a cyclical sequence of behaviours that includes a piece of behaviour tagged "irrational" or "symptomatic". Since the function of the cycle is to maintain homeostasis, "getting one element to change would only cause the other elements to readjust so that the outcome was the same" (Hoffman, 1976, p. 502).

When an ecological relationship system is described in cybernetic terms, the description depicts the symptom as a message in an interconnected relationship network with feedback structure. This form of interconnectedness allows for the symptomatic message to shift from various individual sites. As we have seen, the cybernetic loop of which the symptomatic message is a part can be described as having a homeostatic function. The obvious implication for the therapist is that s/he should diagnose and treat the relationship network rather than focus exclusively on any isolated part (Keeney, 1979).

When behaviour is labelled as "ill" or "dysfunctional", it becomes difficult to consider that behaviour in any other way. The naming created the pathology, but we tend to forget the original distinction that erected the label and the specific circumstances to which it was applied.
"If I say of myself I am an "introvert", I am likely to be caught in my subject-predicate trap. Even the inner self - my self becomes burdened with the onus of actually being an introvert or of finding some way to be rid of the introversion that has climbed on my back. What has happened is that I named myself with a name and, having done so, too quickly forgot who invented the name and what s/he had on his/her mind at that time. From now on I try fanatically to cope with what I have called myself. Moreover, my family and friends are often willing to join in the struggle" (Kelly, 1958 in Feixas, 1990, p. 10). This vicious cycle is known as the - "self-fulfilling prophecy". Thus, to name, to classify, to label another person "affects that person immensely" (Foudraine, 1974, p. 381)

Szasz sees as the motive for making a 'thing' of people an attempt by the psychiatric labellers to exercise control over the other person: "'To classify human behaviour is to constrain it.' To attach a label to a person is to pigeon-hole him" (in Foudraine, 1974, p. 381).

One of the major concerns of the systems approach to therapy deals with the use of labels and their function in the system's construction of the problem. The original Milan team wisely warned us of the danger of predicative structures using the word "is". This use confers objective value to the problem's label (Feixas, 1990). The very act of labelling is itself part of the cycle.
The use of the "reframing" technique proposed by the structural approach (eg., Minuchin, 1974; Colapinto, 1982, in Feixas, 1990); and by the Mental Research Institute (MRI) group (eg., Watzlawick, Weakland and Fisch, 1974) aims at loosening the label applied to a symptom to allow for an alternative which presumably leads to more viable realities. Others (eg., Goolishian & Anderson, 1987; Loos & Epstein, 1989, in Feixas, 1990) have also stressed the role of language in the creation and maintenance of problems.

Scheff (in Foudraine, 1974) started his sociological analysis of what 'being mentally ill' really is by referring to the work of Howard Becker. Becker introduced the concept of 'deviance' in an original way:

Social groups create deviance by making rules whose infraction constitutes deviance, and by applying those rules to particular people and labelling them as outsiders...deviance is not a quality of the act the person commits, but rather the consequence of the application by others of rules and sanctions to an 'offender'. The deviant is one to whom the label has successfully been applied; deviant behaviour is behaviour that people so label. (in Foudraine, 1974, p. 381)

The main question, then, is what rules and norms are infringed, that is, what type of conduct invites us to use, not the label
'criminal,' 'delinquent,' 'eccentric,' but the label 'mentally ill.'

Perhaps the first formal diagnostic statement made by the therapist should be one of redefining the symptom/problem in interpersonal terms. This has the advantage of helping both the clients and therapist(s) to see the symptom as part of a relationship system rather than exclusively located within one individual (Keeney, 1979).

The major implication for diagnosis is that the therapist can come to know the properties of a whole system only by interacting with it. Varela (1976) suggests that "we interact with a system by poking at it, throwing things at it, and shouting at it and doing things like that, in various degrees of sophistication" (p. 28). These perturbations or constraints on the stability of a system result in the system either 'compensating' or 'not compensating'.

When a therapist interacts with a system such that the system compensates, the system can be said to have integrated the therapist as part of its previously structured relationship network - morphostasis or homeostasis is achieved. When the therapist's interactions with a system cannot however be compensated, the system restructures its relationship network so that the therapist can be part of a new pattern - change or morphogenesis is achieved. The goal of therapy is the
establishment of new relationship networks within the ecological relationship system such that symptomatic communication is not necessary (Keeney, 1979). However, if the system's stability is compensated, the therapist becomes impotent.

3.10 The Relation between Ecosystemic Epistemology and the Process of Diagnosis

Diagnosis can be seen as how one comes to know the ecological relationship system that emerges in the process of diagnosing. This way of diagnosing is "Taoistic - one does not purposively seek information in any strict programmed format, but one becomes receptive to the experience" (Keeney, 1979). In other words, the experience happens instead of being made to happen. This way of diagnosing or knowing, shifts constantly and does not constitute a separate component of the therapeutic process. Minuchin (1974) calls this an "evolving diagnosis related to the context" whereby "diagnosis and therapy become inseparable" (p. 131).

On the other extreme, Whitaker in his essay "The Hindrance of Theory in Clinical Work" (in Keeney, 1979), argues that theories get in the way of "Being" or Taoistic knowing. What he means by "theory" is a set of systematic procedures regarding how to think and do therapy.
The idea that one needs a systematic guide for diagnosis and/or therapy arises from a linear epistemology, whereas ecosystemic epistemology is in tune with a Taoistic, nonpurposive, process-oriented way of knowing (Keeney, 1979).

3.11 The Problem and Solution as One

To escape a lineal model it is necessary to view the problem and the solution as one. If therapists view the problem and solution as one, they escape the temptation to fall prey to a search for pathology. It is implicit in what has already being said that lineal epistemology in itself is a source of pathology. A lineal epistemology presupposes the unilateral influencing of one person, agent or group. Furthermore, a lineal epistemology leads to reductionism where the focus is on a small part (sequence) of a cybernetic cycle, without taking the consequence of this focus into account, in terms of, higher-order cybernetic levels.

On the level of an individual as a system, this lineal assumption leads to an alcoholic seeing himself as a separate entity who has control over alcohol as a separate entity, and this leads to a perpetuation of his drinking problem (Joubert, 1987).

Seeking patterns and sequences of interaction, without any judgment with reference to health or pathology, represents what Keeney (1983) terms aesthetics.
If psychologists are then forced to talk of pathology or health, it is important to realise that these are not real entities, but arbitrary punctuations, which can only have heuristic value (Joubert, 1987). If reification of such punctuations take place, we lapse into a lineal and potentially hazardous model (Bogdan, 1984).

3.12 First and Second-Order Change

While it is relatively easy to establish a clear distinction between first-order change and second-order change in strictly theoretical terms, this same distinction can be extremely difficult to make in real life situations (Watzlawick et al., 1974). At times, inattention to this difference and confusion between the two levels of change can occur very easily, and actions may be taken in difficult situations which not only do not produce the desired change, but compound the problem to which the "solution" is applied (Watzlawick et al., 1974). For example, sleep is by its very nature a phenomenon which can only occur spontaneously. It cannot occur spontaneously when it is willed. But the insomniac who is increasingly desperate to fall asleep is doing just this, and his attempted 'cure' eventually becomes his disease. With his increased desperation there results "more of the same" and an escalation of behaviour. Thus, rather than solving his problem, he intensifies it. The solution becomes the problem. This is known as first-order change. The solution lies in letting the person abandon all
attempts to fall asleep (Watzlawick et al., 1974). Interventions of this nature are called paradoxes (Watzlawick et al., 1974); counterparadoxes (Selvini-Palazzoli et al., 1978) and paradoxical injunctions (Hoffman, 1981, in Joubert, 1987).

This first-order change appears to occur in the "revolving door syndrome" - whereby there is "more of the same" solutions being implemented, resulting in the same patterns, sequences and organisation of behaviour of the patients. This in turn brings about the concepts of 'escalation of behaviour' and the 'self-fulfilling prophecy'.

Second-order change is therefore needed in order to break this vicious cycle and can according to Watzlawick et al. (1974) be described as follows:

(a) "Second-order change is applied to what in the first-order change perspective appears to be a solution, because in the second-order change perspective this "solution" reveals itself as the keystone of the problem whose solution is attempted.

(b) While first-order change always appears to be based on common sense (for instance, the "more of the same" recipe), second-order change usually appears weird, unexpected, and uncommonsensical; there is a puzzling, paradoxical element in the process of change.

(c) Applying second-order change techniques to the "solution" means that the situation is dealt with in the here and
now. These techniques deal with effects and not with their presumed causes; the crucial question is what? and not why?.

(d) The use of second-order change techniques lifts the situation out of the paradox-engendering trap created by the self-reflexiveness of the attempted solution and places it in a different frame" (pp. 82-83).

Watzlawick et al. (1974) found that in the deliberate intervention into human problems the most pragmatic approach is not the question why? but what?; that is, what is being done here and now that serves to perpetuate the problem, and what can be done here and now to effect a change? In this perspective, the most significant distinction between adequate functioning and dysfunction is the degree to which a system (an individual, family, society) is able either to generate change by itself or else is caught in a "Game Without End" - i.e., where the attempted solution becomes the problem.

In psychotherapy it is the myth of knowing "why?" as a precondition for change which defeats its own purpose. The search for causes - by therapist, patient, or both - can lead only to "more of the same" searching if the insight gained thereby is not yet "deep" enough to bring about change through insight.
From the above it is therefore evident that first-order change refers to change within a system and second-order change refers to a changing of the system itself. According to Watzlawick et al. (1974) second-order change cannot be generated from within a group. It requires that a change be fed in from outside the system. This assumption rests on the theory of logical types. Second-order change is on a higher level of abstraction than the level at which the problem is experienced.

Hoffman (1990) views second-order change as being one where therapists move away from designing specific strategies for change, away from giving direct interpretations or suggestions regarding behavioural or interactional changes, away from assessment or diagnosis in therapy, and away from communicating normative ideas regarding systemic health. Hoffman (1990) sees a second-order family therapy as moving toward setting a context for change rather than suggesting specific changes, and toward seeking to change premises and assumptions rather than behaviours.

To think in a cybernetic manner and to obtain "aesthetic understanding" (Keeney, 1986, in van der Velde, 1989, p. 79) is to acknowledge the various fragments of a system within the whole system and to search for the patterns that connect the system. This search allows us to respect all parts of our experience. The patterns which we find, the distinctions which we draw and the structures we observe are all "creatures of our measuring
mind" (de Shazer, 1983, in van der Velde, 1989, p. 79).

An important method of facilitating change is to acknowledge the autonomy of a system. The patterns of relationship in a system are unique and prerequisites for change demand that it fits both the external demands of the environment and the internal coherence of the system. Information introduced into a system to effect change should thus fit the autonomy of the system in order to be accepted by the system. Boscolo, Cecchin, Hoffman and Penn (1987) advocate respect for the "systemic wisdom" of the family.

The functioning of a family depends on the ability of the system to adjust to change. If this is impaired, the potential for the development of individual members as well as the family will be restricted. "Changes are inevitable in the life cycle of a family and individual and lead to crises which require new patterns of relationship. The family can only proceed through its developmental stages if it is capable of adjusting to new relationship behaviours. In rigid families that find difficulty adapting to change, psychopathology becomes evident in member/s at times of life cycle changes" (Andolfi, 1983; Simon, Stierlin & Wynne, 1985, in Wittstock, 1989, pp. 102-103).

In order to achieve this second-order change within the system various "strategies" and "interventions" are used - the pragmatics (Keeney, 1983) of the therapeutic process. The formulation "strategy" and "intervention" may seemingly imply a
linear conception, but in order to facilitate conscious conceptualisation and verbal description it has been necessary to isolate simple short arcs of the interlocking circuits within the client and therapist system (Thorp, 1989). Examples of this are given below.

3.12.1 Reframing

If we are able to construct our realities it is important to then pay respect to the way in which we cultivate these realities and the way we can provide useful frames within the therapeutic context (van der Velde, 1989). People become trapped into favoured ways of thinking. Therapy should aim at helping clients free themselves from their confining thoughts through enabling them to discover different connecting patterns which may be more useful to them. In effect, therapists are involved in a reconstruction of a client's sense of reality (van der Velde, 1989). Reframing is changing the definition of reality. Watzlawick et al. (1974) explains that for reframing to be successful the presented problem must be lifted out of a "symptom" frame and placed into a frame which carries the implication of changeability. The aim is essentially teaching the client a different game and thereby a new way of seeing the rules (van der Velde, 1989).
To reframe, then, means to "change the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame which fits the 'facts' of the same concrete situation equally well or even better, and thereby changes its entire meaning" (Watzlawick et al., 1974, p. 95). Thus, reframing operates on the level of meta-reality, where change can take place even if the objective circumstances of a situation are quite beyond human control. In other words a stereotypically "bad" behaviour is provided with a "new chronotope, a new context, in which the bad behaviour is no longer bad, but good. When the stereotype is appropriately reframed in this way, it acquires what is called a positive connotation" (Tyler & Tyler, 1990, p. 108).

3.12.2 Positive Connotation

Positive connotation which is one of the most distinctive procedures used by therapists of the Milan team may basically be seen as a form of the reframe. Its aim permits the therapist to be accepted by the family system, by averting the system's resistance. Selvini-Palazzoli et al. (1990) notes that positive connotation permits us to:

(a) "put all the members of the family on the same level, in that they are complementary in relation to the system, without in any way connoting them moralistically, thus avoiding any drawing of a dividing line between members of the group;
(b) accede to the system through the confirmation of its homeostatic tendency;
(c) be received in the system as full-right members, since we are motivated by the same intention;
(d) confirm the homeostatic tendency in order to paradoxically trigger the capacity for transformation since positive connotation prepares the way for the paradox, 'Why should the cohesion of the group, which the therapists describe as being so good and desirable, be gained at the price of needing a 'patient'?
(e) clearly define the therapist-family relationship;
(f) mark the context as therapeutic" (pp. 61-62).

Reframing and positive connotation exploit the possibilities of "contextual relativity and provide the client family with a new narrative, a new way of thinking and talking about what they had previously thought was a problem" (Tyler & Tyler, 1990, p. 108). Tyler and Tyler (1990) further note that therapists must also not directly attack the problematic behaviour, but rather do something to alter its context and thus change the meaning of the stereotype. The problem is thus not the behaviour but the meaning of the behaviour, and its meaning is both a function of its context and the creator of the context that provides its meaning. "Meanings and contexts are, as in hermeneutics, reflexively emergent" (Tyler & Tyler, 1990, p. 109).
3.12.3 Paradoxical Intervention

The behavioural effect of paradox is, according to Watzlawick et al. (1974) a "peculiar impasse". They cite the example of the "Be spontaneous!" message; "i.e., the demand for behaviour which by its very nature can only be spontaneous, but can not be spontaneous as a result of having been requested" (p. 64). The practical application of this in therapy is often referred to as prescribing the symptom i.e., encouraging behaviour that is presently being fought against.

"By prescribing a symptom to a client the frame of "change" in therapy is addressed as the client is being told to change by staying the same!" (van der Velde, 1989, p. 113). According to Weeks and L'Abate (1982) the solution to this dilemma is the new frame which the client creates to escape from the double-bind in which s/he finds him/herself. Essentially by "prescribing a symptom the meaning attached to it changes: what was previously perceived as being out of one's control is now brought under conscious control by the instruction" (van der Velde, 1989, p. 113). Additionally, say Weeks and L'Abate (1982) "a new kind of feedback is added to the system because each time the symptom occurs, it is because the person wanted it to occur" (p. 23). "The symptom is now no longer what it was, it now occurs within a new frame of understanding i.e. under the individual's conscious control. Furthermore, when the symptom occurs it is both
something the same (stability) and something different (change)" (van der Velde, 1989, p. 113).

Other techniques which are available to promote this second-order "change" such as the use of focused and circular questioning, metaphors, stories, rituals and so on, are unable to be elaborated upon, because of the constraints of this paper.

3.13 Conclusion

This chapter has attempted to show how the newer cybernetic thinking has brought us to the brink of an epistemological revolution. We have begun to be aware of our surroundings, and our realities are no longer limited by the orthodox scientific view. In other words, reality is no more than a construction, an invention, arising out of the way each observer views the world.

From this discussion, it seems important that, in any discussions of reality, we must take care to differentiate clearly between two levels, that of the things and events that can reasonably be taken as being "out there", and that of the frameworks through which these are perceived and interpreted.
Through this position, the therapist is considered to be a facilitator who will utilise what the client presents "as the building blocks and resources for particular interventions" (Keeney, 1987, p. 476). This is a position which is more positive, less judgmental and demonstrates greater respect for the resourcefulness in the clients with whom therapists work.

This systemic approach views everything as interconnected and it is felt that if we continue to understand phenomena in terms of the ecological system then we will be able to achieve a valid contextual epistemology.

However, whilst this "turning point" is challenging and stimulating we may take heed of Keeney's (1983) words of caution that we should never become addicted to any one "punctuation habit" (p. 160). It is important not to ignore the place of linear thinking: as Capra (1985) says, "the reductionist descriptions are useful and may sometimes be necessary" (p. 288).

In the next chapter a practical illustration of the concepts, techniques and understandings outlined above, will be employed in an in-depth case study. Examples of the use of these concepts in therapy are discussed. The examples are drawn from therapy sessions between the researcher and a specific client system.
It was through practical experience while working at the state mental hospital that the writer became aware of the importance of systemic and cybernetic thinking when working with and treating "mental illness". She became aware of the importance of this way of thinking and working, when dealing with the issue of the revolving door syndrome. "Holism" is seen as the key to unlock the ever revolving process...further, the "success of a key does not depend on finding a lock into which it might fit, but solely on whether or not it opens the way to the particular goal we want to reach" (Watzlawick, 1984 in Avis, 1990, p. 84).
CHAPTER FOUR

AN ILLUSTRATION OF THE USE OF CONSTRUCTIVISM AND SYSTEMIC THINKING IN PRACTICE

4.1 Introduction

An in-depth case example will be elaborated upon, illustrating previous methods of treatment, resulting in the "more of the same" treatment, and leading to a vicious cycle. Our aim will be to highlight some of the concepts mentioned in the previous chapter and how "change" was established within the client system to break this vicious cycle.

The methodology used in this investigation was based on the systemic approach described in Chapter 3. It is an epistemology of connecting patterns of social interaction, which links symptomatology to more encompassing family patterns of communication and links the researcher and patient system in similar recursive patterns. The observer and the observed thus each construct their own reality and participate in co-constructing their reality together. The "data" obtained by the observer is a function of the reality of the observer. "When two people interact, each member has a particular view of his flow of interaction. If an observer combines both of these views, a
sense of the whole system will emerge" (Keeney & Ross, 1985, p. 45).

4.2 Description of the Therapeutic System

4.2.1 The Clients

The following is a description made by the researcher of the client system based on the distinctions and punctuations which she drew in both her capacity as observer of and participant in the client system and of the meanings which she attributed to the scenarios.

The context is a psychiatric hospital.

"What we observe is not nature itself, but nature exposed to our method of questioning" (Heisenberg, 1963, in le Roux et al., 1987, p. 7).

4.2.1.1 Biographical Details

The case is that of "Sam", a 35 year old single male who had been in and out of psychiatric hospitals for the past 12 years of his life. However, in the past 2 years, his admission to psychiatric hospitals had dramatically increased, being 8 times in the last 2 years. His last 7 admissions were to a large state psychiatric hospital, at which the researcher was working. His periods of admission ranged between 2 to 3 months. His admissions went from
involuntary to voluntary rehospitalisation.

Sam has lived alone with his father for the past 4 years. His parents were divorced six years ago. His mother and younger sister live in Natal, and his older sister lives in England. He has a very close relationship with his father and feels that he must look after his father. His father had also been diagnosed as a genetically based "depressive". Shortly before his father's divorce, he had been hospitalised for a "major depressive episode". Currently he is stabilised with "medication".

His father occupied an academic post at a college. However, he has now retired and keeps himself busy by building model trains. He has become a lonely and isolated man since his divorce. Leading no social life, he has withdrawn from his social circle of friends. He explained that he feels uncomfortable when he goes out with his "married" friends and therefore prefers to stay at home. He used the metaphor of a "hermit" to describe himself.

Sam was in partnership in his own business which his father had bought for him. He did not enjoy running his own business, as he felt that there was too much stress for him to handle. However, he did not want to disappoint his father and therefore continued to work in the business.

Sam's psychiatric diagnostic labels according to the DSM-III-R, ranged from his being classified as a catatonic schizophrenic to
a bipolar affective disorder, eventually to a schizo-affective disorder.

Treatment in the psychiatric hospital focused specifically from a medical model, emphasising the importance of medication. The emphasis was from a lineal, reductionistic, mechanical and biological model. Psychological help was completely ignored until his second last admission. Until then his treatment consisted in changing his medication and his diagnostic labels. However, what this resulted in was merely "more of the same" treatment being implemented with no significant change evident. The client was being treated within a vacuum, with his context being ignored. The emphasis was that Sam's condition was merely biological, and that he had no control over his illness. The progression of his illness would merely take its natural course.

A feeling of impotence was created amongst the medical profession as well as within the family system. There was "nothing more that anyone could do for him". Sam had given up on himself. He was compliant with his medication. There was nothing more he could do to help himself. His life became focused on his illness.

He was extremely anxious about his condition and felt different to everyone else. In the so-called "real world" he said that he felt as if he were in a "lion's den - wild and unreal". He was
very worried about this - he had begun to withdraw from it, so as to escape the unpleasant feelings. He was very isolated and had become "asocial". He had no friends and had never had an intimate relationship. He was alone in his scared and frightening world - and had no one with whom to share his terrified thoughts and feelings. What was he to do? Sam was "stuck", trapped in this unpleasant world.

Sam was an attractive, well-built man. He walked proudly and appeared confident in his style of interaction. He had great difficulty in opening up and talking about himself and his problems. He preferred to talk about other people and their problems. He had a great concern and interest in other people. He enjoyed initiating philosophical and intellectual conversations about life. Through this way of interacting he tended to distance himself from any kind of emotional intimacy. He would control the types of interaction he wanted. This pattern was evident in all his relationships.

Whenever he spoke about his problems, he would speak in a manner that would indicate that they were out of his control and that he felt helpless and unsure about what to do.

His father on the other hand, was very open and willing to communicate. He not only spoke about his problems but identified what Sam's problems were for him and what he thought that Sam
needed to work through. Sam would not come to the sessions when his father was present, because he said that he knew that his father would speak for him and therefore there was no point for his presence in the session. His father appeared to be over involved with Sam, with Sam taking a more distanced role.

The interaction between Sam and his father appeared as follows: Sam presented himself as removed, distant, uncommunicative about himself, withdrawn and asocial within his family situation and outside in the community. However, in the hospital situation he was over involved with the other patients; enjoyed helping and looking after them; did not want to get transferred from the closed ward to the open ward because he would leave all his "brothers" behind. His role was that of the "helper", "rescuer" within the hospital context. He was friendly and sociable. All the other patients admired and respected him. He felt "free" and comfortable in the hospital.

Sam's father on the other hand, became "useful", protective and gave him love when he was at home.
4.2.1.2 Hypotheses concerning the Client System

This was a single parent family. The departure of Sam may leave only his father "within the family", and this may be an unacceptable position for the lonely parent. A threatened change in membership makes the family unstable and family behaviour may become problematic. Sometimes however, the young person becomes the focus. This behaviour requires the other family members to invest all their time and energy into the problem person, and thus the rest of the family becomes stable (Haley, 1980). Furthermore, it is normal for a young person to gradually start forming intimate relations outside of the family of origin. If the family needs the young person to remain at home, it will most likely develop a method to ambush any attempts to form intimate relationships with others outside of the family. The family boundaries will be made largely impermeable, as evidenced in this family system.

Via institutionalisation, medication and therapy, the family can state that it is trying to deal with the situation, whilst actually never having to worry about true change ever occurring. One will often notice that families and parents will tolerate very deviant behaviour from their children (Haley, 1980).

The main goals of therapy were to assist Sam in gaining control over his symptoms; altering the family relationship and working on the theme of independence and dependence. The main aim being
to try and alter the need for the revolving door syndrome (i.e., the continuous need for rehospitalisation) and to try to change the family system's mode of functioning.

Another fundamental social problem was the failure to disengage, either from the individual or from the family's side. No external intimate or social base was formed. Sam failed to succeed and thus required continued support. There was failure of the family to change the eccentric behaviour, and instead agents of social control were used.

4.2.2 The Therapist

The above description indicates how the researcher has developed building blocks to construct a picture of the system. A descriptive frame was created by the researcher to reveal the understanding which she obtained from observing and participating in the client system. This frame provided a perspective which could lead to problem exploration and resolution. However, instead of "more of the same" treatment being implemented, an alternative way to viewing the problem was established. Second-order change was now in operation.

It is important that the researcher be aware of her construction of reality and of the client system's constructions. All the realities must be acknowledged with the awareness that one can
not easily be superseded by the other.

The following descriptions attempt to describe how therapy sessions were worked through with the conceptual framework of constructivism and the systems view of process. The aesthetics and pragmatics of the ecosystemic paradigm were further utilised in bringing about "change" to the system.

The researcher had the advantage of being assisted in this case by a colleague of hers. Various hypotheses and strategic interventions were discussed. Numerous "realities" were co-constructed in order to direct the therapeutic process. However, when Sam was transferred from the ward in which the researcher was working, her colleague took the case over. There were regular consultations between the researcher and her colleague. The researcher followed the case very carefully. Once Sam was discharged from hospital a regular monthly follow-up was undertaken for a period of 6 months.

4.3 Context of the Client System

Prior to psychotherapy, Sam's problems/symptoms were considered as arising as a result of inherent, biological causes. Now, with the conceptual framework outlined above, patterns and sequences were focused upon. The family system and wider context were also
taken into account.

It became evident, that both Sam and his father had an incredibly enmeshed relationship. They were both dependent on each other, with his father having a strong need for this kind of relationship. Sam felt his father's strong need for this dependence. He in turn felt guilty about his parents' divorce and wanted to give his father the support that he needed. Sam felt guilty if he left his father at home alone and went out with his friends. As time progressed he became more isolated and withdrawn from his social situation.

He would compromise his situation for the sake of maintaining his family system. The symptoms that Sam began to develop were illustrative of the negative symptoms of schizophrenia as outlined in the DSM-111-R. They were, poverty of speech, blunted affect, apathy and social withdrawal.

When he was admitted to hospital, all the positive symptoms were evident; those of, auditory hallucinations, delusions, thought disorder and bizarre behaviours (DSM-111-R). Once hospitalised there would be an indifference to being discharged - at times, he himself even voluntarily came to hospital and admitted himself.
4.4 Symptoms seen as Metaphors for the Whole Ecology

Cybernetics proposes that we see symptoms within the context of recursive feedback. To understand this we must remember that all systems achieve stability via a process of change. There are several ways in which an individual's behaviour and emotions can be seen to change. For example, a child may alter his feelings about his parents, shifting between love, hate, frustration, excitement, and so on. If the systemic organisation of his feelings is self-corrective, he will be described as having a "balanced" or "stabilised" emotional life. Another pattern of organisation involves the escalation of a particular emotion or behaviour. For example, an initial discouragement may escalate into metadiscouragement, or what is called "clinical depression" (Keeney, 1983, p. 123).

These patterns of organisation begin to suggest how pathology or symptomology contribute to the achievement of stability through change. Namely, symptoms are a sort of "escalating sameness" (Keeney, 1983, p. 123). What changes is the intensity of a particular emotion or the extremeness of a behaviour. Symptomatic behaviour is analogous to being in quicksand, where struggling in the same place results in escalating sameness (Keeney, 1983) or a "game without end" (Watzlawick et al., 1977).
Symptoms may also be viewed as a systems effort to maximise or minimise a particular behaviour or experience. This process results in what at first appears to be an escalating runaway. Any individual perceived as the "site" of a runaway behaviour becomes socially labelled as "bad, mad, or sick". The runaway behaviour, however, is eventually curbed by higher order feedback processes such as encountering therapists with their respective calibrating acts of institutionalisation or sedation. It is important to realise that the social system surrounding symptomatic behaviour typically calibrates its escalation (Keeney, 1983).

Since symptomatic behaviour is part of a larger interpersonal gestalt, an individual's symptom may be taken as a metaphor about his interpersonal relationships. Sam's symptoms of extreme withdrawal and bizarre behaviour could be indicative of the pathological closeness he was experiencing within the family system and his need for independence. His need for change and distance was accomplished through his admission to hospital.

This view of symptomology suggests that any pattern of behaviour that can be characterised as an effort toward maximising or minimising a variable is pathological. Keith (1980, in Keeney, 1983), noted that, when there is an identified patient in a family system, the other members who are not identified as having any symptoms, may also be defined as pathological. Whitaker (1979, in Keeney, 1983) expands on this notion when he suggests
that there are pathologies of "always exhibiting 'good' behaviour" (p. 123). He calls this category of psychopathology, "the white knight". Thus, a person's escalating behaviour of symptoms (e.g., withdrawal) may be "in synch" with another person's escalating "perfect behaviour", "call for hope", or "rationality" (Keeney, 1983, p. 123). In this way the ongoing relationship between these different forms of emotions and behaviours creates a whole interactive system. Encouraging a white knight to be less than perfect becomes a strategy for alleviating the presenting symptoms.

Relating this to Sam's and his father's behaviour, it became evident that the more Sam withdrew the more his father became "protective", "overinvolved", "enthusiastic" and "caring". The aim of therapy became one of allowing and encouraging Sam's father to withdraw on an increasing scale. The focus was placed on Sam's father, diverting the attention from Sam. In other words, it became evident that each family member's pattern of behaviour and experience is as pathological (or normal) as that of any other family member. This view enables the therapist to regard the whole family as the client and to engage in the technique called "moving the symptom" (Keeney, 1983, p. 124).

What became important was to look at the symptoms with which Sam was presenting and to ascertain what the meaning of the symptoms meant to him. The aim was to try and change the vicious cycle to a more adaptive spiral. It was hypothesised that
rehospitalisation meant escape from the stressful home situation he was experiencing. It was a "cry for help"!

Usually the person who presents with "symptoms" is sensitive to the disruptive system and aims to change the rigidity of such a pathological system. The Milan team (1990) notes, that the identified patient can be seen as the nodal point at which to enter the system.

4.5 Co-constructing the Therapeutic Reality - Semantics

The researcher explored the meaning of "hospitalisation" for Sam. According to him it was a means of "escape". Whenever the system became too rigid in its ways of functioning - too intrusive and demanding - he had to find a legitimate way of leaving without disrupting the system too much. The easiest and most legitimate way of escaping was to return to hospital (Haley, 1980).

For him "hospitalisation" meant a time to "be yourself", freedom - a place to be with other individuals with whom he could identify. When he was admitted to hospital he was floridlly "psychotic". Inappropriate sexual behaviour was noted - with manifestations of an increased sex drive. This was explored in therapy. Sam explained how he could never have a girlfriend because he would then have to leave his father. Masturbation appeared to be a forbidden act in the system, viewed as it was
with a great deal of disapproval. Guilt surrounded this issue. When he was at home this behaviour never occurred. It appeared that if he would express or act out his sexual desires it would mean the need for having an intimate partner — which in turn would disrupt the closed, intimate system. Therefore, it meant that all the behaviours had to preserve the ongoing rigidity of the system. Disruption would mean the collapse of the system. Thus, hospitalisation allowed for the "legitimate" expression of such desires in that such expression would be out of his control and rather in the control of his "biological illness". His inappropriate behaviour would be seen as a manifestation of his "illness" and therefore there was "nothing he could do about it".

However, it is important to realise that the cybernetic system's maintenance of a symptom does not necessarily include the whole family, nor is it necessarily limited to that social group. Sometimes it is even necessary to interdict the self-defeating efforts of family members to be supportive and encouraging which would sabotage the need for the patient's symptoms (Watzlawick et al., 1974). Furthermore, the cybernetic view does not necessarily suggest that we shift our punctuation from a "disturbed individual" to that of a "disturbed family" (Keeney, 1983, p. 125). Rather, it identifies particular ways in which individuals and families maintain an organisation through recursive process. Cybernetic epistemology involves moving away from blaming identified patients or their families for their problems. It sees symptoms as metaphors for a whole ecology.
There is no longer any gene, chemical, individual, group, or culture to blame and be angry with (Keeney, 1983).

4.6 Circular Versus Linear Punctuations

Initially Sam's problems were punctuated from a linear viewpoint, whereby the focus proceeded from a medical model. His problem was seen as being purely biological and therefore he had no control over it. He was seen as the victim of his problem. Responsibility lay with his compliance to take his medication - and with the help of his father to ensure that he was taking the correct medication. Careful monitoring of his medication was dutifully performed by his father.

Sam had tried most of the medications available - from neuroleptics to tricyclics to lithium etc. His father would "monitor" his behaviour according to the medication Sam received and would write notes to the doctors such as: "really not a very successful weekend on his current level of medication".

Readmission seen in this light is a message from a rigid family that is not able to change its way of functioning. The family's way of maintaining equilibrium or attempts at changing are to return the patient to the hospital. Escalation of sameness is evident in this family system.
In the therapeutic context, a circular, cybernetic approach was undertaken. Patterns and sequences in the system were focused upon. Specification of both the social organisation of the problem behaviour (i.e., the "political" frame) as well as the semantic frame were aimed at specifying the meaning of the behaviour. The goal was to build a view of the political and social frames so that an understanding of the situation could be made in order to create a suitable intervention.

4.7 Extracts from the Therapeutic Process

This family system was entrenched in its way of functioning and viewing the problem. It was a purely biological problem as well as being genetically inherited. This caused Sam's father to feel incredibly guilty in that, he felt he had caused Sam's problems because of his genetic vulnerability to "depression". He tried to compensate for this guilt by becoming over involved in Sam's illness. He wanted to share the burden with his son and therefore he had to do something about it. The genetic link also caused a tremendous bond between the two. They could strongly identify with each other and felt they experienced similar "realities".

Sam's father came to a session alone. He felt he needed to share something with the researcher. When the researcher tried to include Sam in the session (to avoid taking sides, dividing loyalties, diminishing trust etc.) he refused to come to the
session. He explained how his father would "speak for him" and therefore there would be no point to him being there.

4.7.1 Individual session with Father (F)

F presented with concerns regarding Sam's unhappiness and loneliness, which F viewed as possible signs of a genetically transmitted depression. F cited his own history of depression as evidence for an inherited, genetic depression in Sam (i.e., meaning of the problem). He stated that his efforts to comfort, reassure and protect him were ineffective and feared that these signs would exacerbate, dooming Sam to the same "life of hell" that he was experiencing (political frame utilised here - eg. what F does when Sam is feeling down).

4.7.1.1 Comment

Given the strength of the client's beliefs regarding the biological, genetic risk to his son, the researcher chose to intervene within the parameters of the client's meaning system, and accepted the client's view of depression/symptoms. Accordingly, the researcher utilised clinical content derived from literature on biological/genetic depression and linked it to a diathesis-stress paradigm (Davison & Neale, 1986). The researcher suggested that, given the familial predisposition to depression, environmental factors could be critical in the expression of the predisposition. Since the depressive tendency
This intervention was specifically designed to influence F to withdraw and lessen his involvement in Sam's life – changing the politics ("rules") in the family system. The problem was viewed as embedded in the interactive process surrounding F's attempts to help Sam. The researcher believed that directly suggesting that F withdraw his involvement would be met with noncompliance and would feel disconfirmed. This in turn would lessen the researcher's credibility.

Accepting F's meaning of Sam's behaviour enabled the researcher to prescribe different behaviours based upon that meaning. Such an acceptance and utilisation of a strongly held client meaning not only provides the direction for intervention, but also enhances compliance and the likelihood of a successful outcome. The selection of the content for both the therapeutic conversation and intervention was directed by the client's idiosyncratic presentation of genetic depression. (This strategic intervention was adapted from Duncan et al., 1990).
4.8 The Power of the Metaphor

Papp (1984) notes that the effectiveness of a metaphor used in therapy lies in the fact that it is aimed at "bringing different levels of thought, feeling, and behaviour together into a unified theme" (p. 23). Through this creative act a new set of rules and meanings are introduced which suggest new definitions and interpretations of the situation.

In therapy, Sam and his father were given the metaphor that they were like "husband and wife". The "couple" strongly identified with this. It was used as leverage to enable them to understand what was happening in the relationship between them as well as the issue of dependence versus independence. The use of a metaphor was particularly effective in this rigid and defensive family because it enabled the couple to communicate about a problem or issue metaphorically, thereby avoiding direct and explicit reference to the presented issue. Furthermore, the metaphor itself became a conduit through which meanings, perceptions and values were attributed. Lakoff and Johnson (1980 in van der Velde, 1989) point out that metaphors can shape and permeate the way we think and act which was clearly evident in this case.
F was identified as the devoted, concerned "wife". He was the one to stay at home when Sam went to work. He would greet Sam when he came home and offer him a cup of coffee. While F was preparing dinner, Sam (the so-called "husband") would watch television and read the newspaper. At dinner time, F would ask how his day was at work etc.

The aim of this metaphor was to ascribe different meaning to the problem situation. It is a somewhat extended version of reframing, i.e., the meaning or interpretation attributed to the situation is altered or redefined, and therefore it follows that its consequences must change. The therapist-generated reframes seek to promote immediate behaviour change (Duncan et al., 1990). The particular ascribed meaning is collaborative in the sense that it emerges from the interaction between the therapist and client system. Since no "particular theoretical or content path must be exclusively utilised, meaning may be ascribed from any content area as long as it is consistent with the emergent reality that is constructed in the therapeutic conversation. The goal of meaning ascription is not to establish a 'true' or 'better' meaning, but to encourage a change in meaning which will permit clients to reorganise the experience that maintains the problem" (Duncan et al., 1990, p. 575).
The researcher suggested that perhaps the use of the relationship functioned as a means to protect Sam from having an intimate relationship with someone else - seeing that he was already in a "marriage" he did not need to find another partner.

This seemed to distress the couple immensely and upon the next individual session with Sam, he started talking about moving out of home and the need to find a girlfriend - the issue of independence thus became dominant.

Furthermore, his behaviour within the hospital began to change. He became more friendly with the females in the ward, and formed a very close bond with one female in particular. This was quite contrary to his behaviour displayed previously.

His need for rehospitalisation began to diminish as the system changed from something out of his control to something he could proactively address - that is, to take responsibility. The new information led to change; change of meanings and rules and vice versa.
4.9 The Need for Rehospitalisation

Within the home environment, Sam portrayed a very passive role. He lacked responsibility in all facets of his life. His father would do all the "worrying" for him. This included his reminding Sam to take his medication and he would wake him up in the morning for him to go to work.

However, in the hospital environment, Sam portrayed a very different role. He was very active within his ward, partaking in ward duties; attending individual and group psychotherapy; he was seen as the "helper" in the ward - worrying about the other patients etc. Self responsibility and self control were furthermore noted. Especially in group therapy - Sam was seen as the "leader". He interacted well with the other patients. He was confident and constructive in his participation and would contribute meaningful and relevant feedback/information to the other patients. He was a valuable member to the group situation. This behaviour was quite contrary to that seen in his home environment.

Because Sam believed that he had no control over his "illness" - or his family situation (his father) - there was a further entrenching of his passive behaviour.
In the therapeutic process we explored the meaning of this "passivity". It became evident that for a period of six consecutive years, he had not been hospitalised. Together we tried to ascertain what was different then as opposed to now, which resulted in his frequent readmissions.

It became evident that in the period of 6 years that he was not hospitalised, he had a very "active" role in life. He partook in a great deal of physical exercise (he ran in the Comrades Marathon); he was studying; doing "odd jobs"; socialising with his friends and appeared to have enjoyed life more. During this time, his parents were still married, so he did not have the burden that he had to be at home all the time with his father.

Haley (1980) explains that the main theme that underlies problem young people is the issue of failure. When such people are faced with achieving success, they will create a situation to cause failure. The reason for this is that "success" is defined as having behaved competently and with having formed successful intimate relationships outside of the family. The rationale is that if one can do this, then one can leave and eventually form one's own family. Thus, eccentric young people are most likely to fail just as they approach success.
Haley (1980) maintains that eccentric behaviour is essentially protective. All behaviour is seen to aim at stabilising the organisation. The disobedient behaviour may be viewed as an attempt by a young person to tell the family to organise itself on a more stable base. In addition to this, such young people may engage in such "sacrificial" behaviour both consciously and willingly.

Eccentric behaviour is differentiated from other behaviour by the fact that the individual does not hold himself responsible for his actions. In all eccentric behaviour the young person first breaks some social rule, and then follows this with an indication that it is not his fault. The avoidance of assuming responsibility then spreads through the system - from parents, to family, to society. This results in the hierarchy of the system being in a state of confusion, with no-one being able to assume authority. Eccentric behaviour serves to stabilise the system and clarify the hierarchy. Haley (1980) maintains that the young person must be directed to take responsibility for his behaviour.

Since his frequent readmissions Sam's "illness" seemed to overtake his life. It was as if he would merely wait for the time that he would get sick again. "Passivity" thus began to appear. He did not enjoy his work anymore and life became a threatening and terrifying experience for him. In therapy, we focused on organisational issues, and anticipated that when Sam becomes "normal", the family system would become unstable.
Emphasis was placed on the fact that Sam is normal and capable of success. The researcher explained that he was placed in hospital because his behaviour was disruptive to the community, and not merely because he was a failure.

With this, new meaning was obtained to his problem situation. Sam realised that he could do something about it. A new reality was constructed for him.

4.10 Evidence of Change

In one of the follow-up sessions after his discharge, Sam explained how he had returned to doing physical exercise; had sold his share in the business; had begun to make contact with some of his old friends; was going out more often and seemed to being enjoying life more again. He had also decided that he was going to move out of home. He spoke in a confident manner and was taking responsibility for his own life.

This change of behaviour can thus be seen as the beginning of the end of the vicious cycle of rehospitalisation. He no longer felt trapped in his negative mode of functioning. A freer more healthy individual had begun to emerge. However, it is important to remember that this is only the beginning of the new adaptive spiral that Sam has begun to attain for himself.
Sam began to realise a new meaning to his symptomatic behaviour and decided to give up the burden of carrying the symptoms of a dysfunctional system.

In understanding the process of therapeutic change we must address the varying patterns of communication rather than concentrating upon reified descriptions of biochemical, psychological, or social components. In this case, therapy provided a context wherein the family could change the way they change in order to maintain their stable organisation. This change of change required that the researcher not only had to accept and respect all the communication that the family presented, but also ensured that the researcher had to challenge it as well (Keeney & Ross, 1992).

4.11 Therapy: The Technique of Interpersonal Collaboration

In therapy, the therapists' aim is to assist their clients in developing new constructions or "maps" of reality that enable them to experience their realities in different and more satisfying ways. This frees clients from the shackles of their entrenched constructions (van der Velde, 1989).

However, what is important is that this new information, "meaningful noise" (Keeney, 1983) must fit with the system. It must be relevant and meaningful to the system and it must enable
the system to use this information so that it can transform itself to a more adaptive state of functioning. Furthermore, the "meaningfulness" of the new information must also take into consideration the readiness of the recipient for the information (Bateson, 1979; Dell, 1982a; Keeney, 1983). A system will only respond to information when it is ready for it. A successful therapeutic session will therefore be largely determined by the therapist's sense of appropriateness and timing (Silverstein, 1986, in van der Velde, 1989).

Therapy is a collaborative effort between therapist and client. Whilst the therapist may facilitate change through various techniques, it is often the "extraordinary resourcefulness, courage, sensitivity, and imagination of the recipients who use what therapists gave them to transform their lives" (Papp, 1984, p. 25). Papp (1984) further notes that it is "impossible to predict the outcome of any particular therapeutic thrust. Sometimes clients turn our most mundane interventions into transcendental experiences, while at other times, they remain totally impervious to our strokes of genius" (p. 25). The therapist's interventions must match the client's context and be an extension of that client's own frame of reference. It must fit in with the network of presuppositions, for if the information "does not have meaning in this context it is forgotten or 'blurred'" (White, 1986, p. 170).
Although the therapist provides a new alternative frame or "reality" for the client, s/he has "no control over the interpretation and meaning which the client will attribute to the new frame. The outcome of therapy can be considered to be the interaction of the frames which both the client and therapist bring to therapy and as well as those which are constructed during the therapy sessions" (van der Velde, 1989, p. 119). Therapists can not presume that they can provide any definitive answers: "they work with ever-changing complexities over which they have little or no control. They never know for certain the limits or possibilities of their material, nor the exact nature of it" (Papp, 1984, p. 25). The most that therapists can do is raise questions for which the clients will provide the answers! Thus, interventions are unpredictable as there are numerous options open to the client system in terms of the interpretation given to the new information.

Through the therapeutic interventions with this client system a collaborative effort was established. By constructing "new realities" through the use of "meaningful noise" at the appropriate time and readiness of the client; Sam was able to experience more freedom to make and act on choices in his life. He was able to provide new meanings for himself so that he could perceive himself differently. He was able to change his perceptions of himself and his environment from negative to positive. His new perceptions led to a change of attitudes and behaviours and vice versa. These circular transactional feedback
patterns inevitably lead to a change in his functioning and to a more adaptive pattern of living. The use of rehospitalisation became redundant. New meaning was established to his "old" mode of functioning, which in turn brought about the change.

4.12 Comments and Conclusion

This family system was able to move from "more of the same" dysfunctional patterns to a more adaptive mode of functioning. One of the issues punctuated in the system was the threat of leaving home. Organisational rules and problem maintaining behaviours were identified. It was hypothesised that if the young person develops a problem that makes him a "failure", he will have to remain at home and the old family system can thus by stabilised again. Once failure to disengage has succeeded once, the "problem" can be used indefinitely to maintain the old system.

The concept of hospitalisation was seen as maintaining certain assumptions which perpetuated the use and need for rehospitalisation. The assumptions which resulted in the "more of the same" treatment procedures without change were that:

(a) The problem was seen in individual terms and not social terms.
(b) Generally the agents of social control (Haley, 1980)
tended to be "anti-family", ignoring the reverberations through the system when an individual was institutionalised.

(c) Medication was widely used, often without taking into account how this could generate new difficulties.

The difference between our therapeutic approach and that of the social control, was that our aim was to allow for the development of the potential in the individual. Repetitive cycles of behaviour were broken down, and the consideration alternatives were introduced providing new information and "meaningful noise" (Keeney, 1983) to the system. Behaviour became more complex and varied in the system. Change and a healthy degree of unpredictability was aimed for.

Therapy often utilised the interaction of others in a context to help the individual (for example, the family, groups, community). The art of therapy was to remain flexible in order to recognise, and make use of, sudden changes.

Content issues were separated from organisational issues. Patterns and sequences were recognised in the system and therapy was guided by the system. What was avoided by the researcher was:

(a) Labelling and treatment which emphasised abnormality.
(b) Imputing to the system what one thought was happening.
(c) Leaving tasks undefined and issues unclear.
(d) Not acknowledging the eventuality of the young person leaving home.

We are not advocating the ignoring of the medical model, but rather its incorporation into our larger system of "thinking". It can be seen as "part of" but not the entire aim of treatment, as this would again become an epistemological error - the ignoring of the context.

The linear approach was not able to bring about a change to the system. Sam's problem situation perpetuated with the result of frequent readmissions. The new thinking was able to bring about a change in perception, attitudes and behaviours which in turn led to an adaptive change of the functioning of the system.

This constructivist approach has far reaching implications for psychotherapy. It served as a reminder of the artificial nature of categories and of the power of a point of view! In these workings "cures and fixed solutions are not offered, but alternative realities are and these are built to transform the meaning and interactional organisation for the people who are part of it" (van der Velde, 1989, p. 165).
CHAPTER FIVE

SUMMARY, RECOMMENDATIONS AND CONCLUSION

5.1 Summary

The aim of this chapter is to link the various concepts associated with readmissions that have been developed in the previous chapters. A critical evaluation of the investigation will be given and future recommendations made.

In the literature survey, many factors related to readmission were discussed. The major area researched was the hospital treatment procedures. The approach was from a reductionistic, biological and causal orientation. The patient was not considered as part of connecting patterns in his/her environment. The issue of the revolving door was not being adequately dealt with by the system. "More of the same" treatment procedures were merely being instituted with no change evident within the system.

The interventions in the hospital were divorced from the patients' problems at home. Patients obtained a temporary respite in the isolated context of the hospital but were not provided with means of coping outside the hospital. Diagnoses were uncertain and investigation and treatment missed the family patterns which maintained the symptoms and rehospitalisation.
The hospital became part of the pattern of interaction in the families by providing rest and strengthening in the cycle of escalating relationship patterns. The patients were discharged strong enough to return to their families. The family interactions continued until their escalation and then the hospital became part of the cyclical process once more.

Constructivism and the systems view of process were defined and used as a framework for this investigation. The ecosystemic paradigm was chosen as the therapeutic model from which to work, wherein other techniques and strategies were incorporated from other approaches resulting in the use of strategic eclecticism.

This thesis has attempted to show that the shift in thinking towards new paradigms has been important both in philosophical and practical terms because it generates a new way in which therapy is conceptualised and conducted.

The exploration of "reality" leads to the realisation that "reality" is a complex matter. Reality is seen as relative to the perspective of the viewer and the new approach allows for the world-view of the researcher and patient as well as a combination of these views to form the widest possible perspective of phenomena.
Throughout much of the literature the message appears that an "adequate" map of the world does not mean it is nearer the truth than any other map. However, the literature does suggest that once we make a commitment to a "truth", we need to then accept the consequences thereof and remember "never to believe what we believe" (Cade, 1986, p. 56).

It was explained that the "realities" which therapists construct in order to devise interventions, are only helpful if there is an appropriate "fit" with the clients' systems' way of thinking about themselves and their constructed realities. The skill appears to lie in the therapist's interventions being close enough to the client system's realities so as to "engage the client, albeit briefly, in a shared reality, yet with a sufficiently different perspective to help bring about changes in meaning and thus in experience and response" (Cade, 1986, in van der Velde, 1989, p. 162).

This constructivistic and systemic approach was proposed as a combination to the present treatment procedures found in the psychiatric hospitals. It's aim was to provide us with a more holistic mode of treatment so that change could occur in the ever revolving process. "More of the same" treatment procedures were being replaced by second-order change, so as to bring about more effective change within the system. A practical application of this mode of working was applied to an in-depth case study.
5.2 Recommendations

Researchers have advocated the "development of co-ordinated, comprehensive psychiatric, psychosocial and medical support resources in the community in order to minimise the use of state mental hospitals by chronic dependent patients" (Winston, Pardes & Papernik, 1977; Sullivan & Borovitz, 1981; Dincin & Witheridge, 1982; Harris, Bergman & Bachrach, 1986; Weltman et al., 1988, in Wittstock, 1989, p. 15). "Comprehensive psychosocial treatment programmes promote a higher level of functioning among discharged psychiatric patients than do a fragmented series of programmes and unrelated treatment modalities because they provide a more gradual, structured, and stable transition to independence" (Weltman et al., 1988, in Wittstock, 1989, p. 16).

In Goodpastor and Hare's (1991) study they found that outpatient commitment can substantially delay readmission and reduce relapse. Glick and Hargreaves' (1979) comparative study of short-term (21-28 days) and long-term (90-120 days) inpatient treatment showed that the schizophrenic patients given long-term treatment clearly did better at follow-up. The authors ascribe this effect to the fact that the patients in the long-term group had the opportunity to develop a relationship with their outpatient therapist while they were still inpatients. It is their clinical impression that one of the crucial problems for
patients is the lack of continuity of care (in Friis et al., 1991).

A study wherein 300 patients "needing hospitalisation" were randomly allocated to either hospitalisation or outpatient family crisis therapy and followed up six and eighteen months later, found that social functioning was equal in both the groups, but the need for rehospitalisation was less in those treated as outpatients (Langsley, Machotka & Flomenhaft, 1971, in Woogh, 1986).

Holistic aftercare is seen to be critical in the reduction of readmissions and should include; (Wittstock, 1989)

(a) social support networks, i.e., family and friends who should also be included in patient counselling;
(b) assisting patients in maintaining social competence and relations in work, with the family and citizenship in the community;
(c) skills training and vocational rehabilitation;
(d) focusing on alcohol and substance abuse;
(e) attending to compliance;
(f) and home visits.
5.3 Conclusion

In the literature review set out above, it is submitted that the major problems attendant upon hospitalisation and hospital treatment were delineated. This treatment was not seen as effective in dealing with the systems. Although the symptoms were removed at the time of hospitalisation, once the patients returned home the vicious cycle began again and they were then readmitted. What all this resulted in was "more of the same" treatment being instituted - first-order change - with no effective change in the system occurring.

The new systemic approach to treatment was explained by the use of a practical case example. Although only one case example was presented by the use of this therapeutic approach and cannot be regarded as sufficient for the generalisation of the results, it has nevertheless shown us the benefits of such workings. It has shown us how mental health should be considered in the network of wider contexts; the family, the community, as well as within the larger socio-economic and political environment.

The clinical psychologist within the hospital context is thus seen as having a major role in illustrating to the other helping professions other ways of thinking and working, so as to try and help diminish the revolving door syndrome and for the more effective/holistic treatment procedures to be instituted. In other words, instead of solely looking at the patient or focusing
upon what is happening in the patient, this approach allows one to explore relationships, patterns and sequences in a given context. This had the effect of "uncovering complex structures and relationships associated with readmissions, which provides a wider contextual view" than the research described in the literature review (Wittstock, 1989, p. 207).

Finally, it must be borne in mind that an examination of a system's "failures" should not be used to condemn the system in general, but rather it can be used to understand better the workings of the contemporary pattern of public-sector psychiatric care and to facilitate its improvement!
BIBLIOGRAPHY


