

SUPPORTIVE PSYCHOTHERAPY:

AN EXPLORATORY STUDY OF EXPRESSED VIEWS, FEELINGS, PRACTICES AND PROBLEMS

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ABSTRACT

Supportive psychotherapy is documented as the psychological treatment of choice for patients with severe psychopathology. It follows that this psychotherapy is particularly relevant to psychiatric hospitals which predominantly treat this category of patient. This study takes place at such a hospital. Problems which have implications for the practice and development of supportive psychotherapy, both at the hospital concerned and in general, have been reported. With a view to addressing these problems at the hospital, this dissertation explores some of the views, feelings, practices and problems regarding supportive psychotherapy reported by a number of clinicians at the hospital. An essentially qualitative research approach, involving interviews with 26 clinicians from various professional disciplines, is employed. A number of potential problems pertaining to terminology, definition, theoretical framework, referral, training and clinician attitudes are raised and discussed. Recommendations are made which are applicable to the hospital concerned, to teaching institutions, and to interested psychotherapists.

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CHAPTER 1: INTRODUCTION

BACKGROUND TO THE STUDY

This study has its genesis in an observation made while working as an intern psychologist in an assessment unit of the Greenwood¹ state-funded psychiatric hospital. Whilst it was relatively easy to refer patients to hospital psychologists for insight-oriented psychodynamic psychotherapy, referral of patients deemed suited to what is frequently termed supportive psychotherapy, or supportive therapy (Bloch, 1979; Buckley, 1986; Geller, 1989; Greenberg, 1986; McIntosh, 1991; Rockland, 1989; Winston, Pinsker & McCullough, 1986), was usually unsuccessful. Furthermore, on discharge, patients were rarely referred to outside agencies for the latter form of treatment. For example, a welfare agency which provided treatment of this nature, was seldom used as a resource. Consequently, most of the patients for whom a form of psychotherapy other than insight-oriented psychodynamic psychotherapy² was indicated, were discharged with no more than the offer of out-patient monitoring and prescription of medication.

Given that the majority of patients attending Greenwood Hospital suffer from severe psychopathology (senior consultant,³ personal communication, 1993) and that it is such patients who, at least in the United States, most commonly receive supportive psychotherapy (Truant & Lohrenz, 1993), the apparent problems of limited availability of, and referral for, supportive psychotherapy⁴ appeared to warrant attention.

Preliminary enquiry

As a first step, exploratory discussions around these apparent problems were held with clinical staff at Greenwood Hospital. These discussions underscored the impression that supportive psychotherapy was inadequately utilized and raised specific problem areas at the hospital: a lack of clarity around definition, assessment and performance, and inappropriate referrals for supportive psychotherapy. Clearly further investigation was indicated and became the aim of this study.

¹ Greenwood is a pseudonym, used to maintain confidentiality.

² Hereafter referred to as insight-oriented therapy.

³ For reasons of confidentiality staff members of Greenwood Hospital will not be identified by name.

⁴ While the terms supportive therapy and supportive psychotherapy are used interchangeably in some of the literature, the latter is used more consistently. For this reason the term supportive psychotherapy is adopted in discussion in this thesis.

The next step, then, involved a review of the American and British literature (no pertinent work from other countries, including South Africa, was found) which provided a broad perspective from which these preliminary findings were explored. In the following section the reported development and status of supportive psychotherapy, views and feelings of clinicians regarding supportive psychotherapy and its patients, as well as issues of terminology and description, will be discussed.

LITERATURE REVIEW

Development of supportive psychotherapy

The following outline of the development of supportive psychotherapy as a treatment method draws on Rockland's (1989, p. 451) review of "psychoanalytically oriented supportive therapy".

Supportive psychotherapy may be traced to the early nineteenth hundreds, to the study of suggestive and hypnotic treatment methods by psychoanalysts Jones, Ferenczi, Rado and Abraham. Although these supportive methods were considered to be helpful to patients, they were generally viewed unenthusiastically because of the belief that only insight, gained exclusively through what is now commonly referred to as insight-oriented therapy, could offer a cure. Shortly thereafter a psychoanalyst, Glover, confirmed the usefulness of suggestion, indicating that it could result in symptomatic improvement. In 1954 Knight articulated a need for supportive psychotherapy for patients who deteriorated while undergoing insight-oriented therapy. Since then various authors have made contributions towards describing supportive psychotherapy as a form of psychotherapy distinct from traditional, insight-oriented therapy.

Status of supportive psychotherapy

The distinction between insight-oriented and supportive psychotherapy appears to have diminished the status of the latter. Supportive psychotherapy has commonly been viewed as a second-rate form of intervention which may be offered when there is "nothing else in our treatment cupboard" (Bloch, 1979, p. 197). In addition, a tendency has developed to view it as "treatment espoused by the uninitiated who believe that psychotherapy is 'all about being nice to people'" (Holmes, 1988, p. 824).

Despite supportive psychotherapy's relatively large application (it is said to be "probably the most common form of psychotherapy used for patients in acute crises and for those with more chronic psychopathology" (Conte & Plutchik, 1986, p. 530)), American literature indicates that in the past it has been neglected by training institutions and researchers (Conte & Plutchik, 1986; Mirabi, Weinman, Magnetti & Keppler, 1985; Werman, 1984).

Werman (1984) adds that supportive psychotherapy candidates are frequently allocated to the least informed and least experienced members of the clinical team (often students), a practice which implies that minimal or no experience or knowledge is required to perform supportive psychotherapy; that it simply means meeting regularly with patients and being supportive. He argues that, as a result, supportive psychotherapy is depreciated and remains poorly conceptualized and practised.

In spite of its negative background there appears to be a recent move towards improving the image, clarity and performance of supportive psychotherapy. Over the past decade the first book dedicated solely to supportive psychotherapy (by Werman, 1984) and numerous articles on the subject have been published (Rockland, 1989). In sharp contrast to what has been said before, many contemporary authors are arguing that a great deal of understanding and skill is required to assess and perform this therapy effectively, that training, supervision and in many cases personal therapy of clinicians are necessary, and that the work may be intellectually challenging. Calls for more writing, research and training in supportive psychotherapy are being made, and it is suggested that senior clinicians become more involved with it, as therapists and supervisors (Buckley, 1986; Greenberg, 1986; Hartland, 1991; Holmes, 1988; McIntosh, 1991; Rockland, 1989; Werman, 1984).

Of relevance to attempts at developing supportive psychotherapy practices are clinicians' views and feelings, about performing supportive psychotherapy, and about its patients. These issues are addressed below.

Clinicians' views about performing supportive psychotherapy

Clinicians have considered the practice of supportive psychotherapy dull and unchallenging. It has been contrasted with the practice of insight-oriented therapy as being "'a simple-minded endeavor' that can be practised without special training" (Conte & Plutchik, 1986, p. 530).

Supportive psychotherapy patients have, according to Werman (1984), similarly been devalued. This issue raises two questions: which patients are generally associated with or receive such treatment, and what are the attitudes of clinicians towards these patients?

Two types of patients are reported to be suitable for supportive psychotherapy: those who are fairly well integrated but who have temporarily become overwhelmed by major stress, and those with severe and persistent mental disorders (Bloch, 1977; Conte & Plutchik, 1986; Rockland, 1989; Werman, 1984). The latter category is emphasized in the literature. Supportive psychotherapy is described specifically for the "chronically handicapped psychiatric patient" (Bloch, 1979, p. 196), and is advocated for patients whose "psychological equipment is fundamentally inadequate" (Werman, 1984, p. 13), and who are "more or less severely arrested in their psychological development" (McIntosh, 1991, p. 27). As mentioned at the outset, in practice (at least in the United States), it is those patients with severe psychopathology who are most commonly provided with supportive psychotherapy (Truant & Lohrenz, 1993).

The strong association between supportive psychotherapy and patients with severe disorders, together with the fact (stated earlier) that Greenwood Hospital accommodates mostly this type of patient, calls for particular attention to the views and feelings of clinicians regarding this patient population.

Clinicians' views and feelings regarding patients with severe and persistent mental disorders

American and British authors suggest that clinicians' views and feelings are largely negative. Working with patients with severe and persistent mental disorders is commonly described by professionals as "unrewarding and dull", "hopeless", and lacking in prestige (Meyerson, cited in White & Bennett, 1981, p. 339) and by trainees "as drudgery [and] unimportant" (Talbot 1984, p. 97). Furthermore, clinicians have been found to resent such patients' dependence on them (Pedder, 1991). A survey conducted at a symposium (held in Houston in 1982) revealed a majority view that most clinicians prefer to avoid contact with such patients and refer them whenever possible (Mirabi et al., 1985). Whether similar views are expressed locally is addressed in Chapter 3.

It would seem that the historically negative views regarding supportive psychotherapy and its patients could hamper the development of supportive psychotherapy as a treatment method. The following two subsections show further areas of potential difficulty: those of terminology and description. But these sections

will also show points of consensus which present a strong case for the existence of a form of psychotherapy which differs significantly from the traditional, insight-oriented model.

Terminology

The literature reviewed reveals inconsistency and potential problems regarding the use of terms related to supportive psychotherapy.

There is inconsistent use of terms in recent literature (e.g. Conte & Plutchik, 1986; Hartland, 1991; McIntosh, 1991; Winston et al., 1986) which uses, without explanation, the terms supportive therapy and supportive psychotherapy interchangeably. (This observation prompted exploration of whether clinicians of Greenwood Hospital similarly considered these terms interchangeable. The issue will be addressed in Chapter 3).

A number of authors caution that the term supportive psychotherapy (or therapy) is misleading and problematic. A commonly expressed concern is that, although the practice of psychotherapy involves fluidity between, and overlapping of techniques of supportive and insight-oriented psychotherapies, the term supportive psychotherapy implies exclusive use of supportive techniques (Frank, 1986; Hartland, 1991; Rockland, 1989; Schlesinger, 1969). Schlesinger (1969, p. 271) expresses a further concern that, as a result of such an implication, therapists attempting supportive psychotherapy may lose interest in, and alertness to, and may even be rendered fearful of, important communications by patients about experiences other than those which relate to the "here and now".

Terminological problems are dealt with differently by various authors. Some refer to a continuum, with supportive and insight-oriented goals and strategies at the two polarities (Conte & Plutchik, 1986). Rockland (1989, p. 452) refers to "'psychoanalytically oriented' or 'psychodynamically oriented'" therapies as "divided into primarily supportive and primarily exploratory [or insight-oriented] modalities". Frank (1986) goes so far as to urge that the term supportive psychotherapy be discarded. In contrast, Schlesinger (1969) proposes that the term be used, not to specify a *kind* of psychotherapy, but more precisely to *describe* psychotherapy. These various views and suggestions will be considered in Chapter 3 in the light of the findings of this study.

In spite of the above concerns about terminology and the view that in practice psychotherapy involves both supportive and insight-oriented techniques, strong arguments in favour of clearly defining supportive psychotherapy as a treatment method are presented. Werman (1984, p. 3), for example, states that

there are substantial theoretical and practical differences between the two forms of treatment... psychotherapists should understand these differences in order to avoid any confusion over the goals and technical procedures which might weaken either therapeutic process.

A recent surge of interest in the area has yielded a number of descriptions of supportive psychotherapy as a treatment method. While there is consensus amongst authors concerning some aspects of supportive psychotherapy, there is remarkable inconsistency and contradiction with regard to others. Areas of agreement and / or difference are discussed in the following sub-sections.

Descriptions of supportive psychotherapy as a treatment method

Goals and aims

The case for supportive psychotherapy as an alternative form of treatment is strengthened in that there is general agreement amongst authors that the goal of supportive psychotherapy is to maintain or improve "internal stability and external adaptation" (Rockland, 1989, p. 460), rather than to attempt cure. The latter goal is usually associated with traditional insight-oriented therapy. Werman (1984, p. 165) explains that in supportive psychotherapy "the major effort ... is to provide what is lacking in ego functions or to enhance what is only insufficiently present". The aims of treatment are said to include those of alleviating painful emotional states, shoring up ego functions, restoring or developing healthy defence mechanisms and diminishing more primitive ones, discouraging destructive behaviour, cultivating effective coping skills, and improving self-image (Buckley, 1986; Werman, 1984).

Theoretical frameworks

Contradictory views are expressed regarding theoretical frameworks. A number of authors (e.g. McIntosh, 1991; Rockland, 1989; Werman, 1984) assert that psychoanalytic theory is necessary to supportive psychotherapy. Rockland (1989, p. 452) emphasizes this view and warns that psychodynamic or psychoanalytic theory is inappropriately yet commonly associated only with insight-oriented psychotherapy. He explains that

the crucial differences between supportive and exploratory (or uncovering, expressive or insight-oriented) psychotherapies are in their goals and in the therapeutic strategies and tactics utilized, not in their theoretical foundations ... supportive therapy is as appropriately described as "psychoanalytically oriented" or "psychodynamically oriented" as is exploratory therapy.

In strong contrast to Rockland (1989) and others, Hartland (1991) states that supportive psychotherapy lacks a theoretical base. Crown (1988), in turn, says that it lacks an overall unifying theory but may draw from various theories (e.g. psychodynamic, behavioural, cognitive and Rogerian).

Possible implications of there being no unanimously accepted theoretical framework informing the practice of supportive psychotherapy are considered in Chapter 3.

Clinical format, principles and techniques

Supportive psychotherapy is commonly described in terms of a dyadic rather than group interaction. (The adoption of this perspective at Greenwood Hospital will be addressed in Chapter 3).

Reflecting the absence of a single underlying theory, the literature reveals a number of commonly reported principles and techniques of supportive psychotherapy which correspond with a remarkable range of theories (e.g. cognitive, behavioural and psychoanalytic). It is said to involve a relatively active and "real" (as opposed to neutral, abstinent and relatively anonymous) therapist, flexibility in method and structure (such as frequency of sessions), a focus on external and interpersonal rather than intrapsychic issues, the provision of advice, encouragement, guidance and reassurance, assistance with reality-testing and problem-solving, cognitive reframing and restructuring, and ventilation of emotion (Bloch, 1979; Hartland, 1991; Rockland, 1989; Werman, 1984; Winston et al., 1986). Reflecting the language of psychoanalytic theory, fostering of a positive transference is said to be appropriate, and the therapist's role is sometimes described as being that of auxiliary-ego or auxiliary-superego (Winston et al., 1986). At the same time, regression, direct confrontation of defences, transference interpretations and other methods of uncovering unconscious material are generally considered inappropriate. Some (e.g. Werman, 1984) exclude interpretation as an appropriate technique.

What is evident is that, despite their different theoretical frameworks, authors provide strong support for the practice of supportive psychotherapy in a way which is different to the traditional insight-oriented therapy.

Even where insight-oriented techniques such as interpretation are proposed, differences are highlighted. Pine (1984, 1986), for example, suggests that interpretations be provided under conditions of increased "holding" and relatively low affective discomfort, that immediate associative responses not be sought, and that the patient's readiness for, and involvement in, the interpretive process be actively encouraged.

In addition to theoretical inconsistencies, Rockland (1989, p. 451) notes that there is "no generally accepted list of supportive interventions in the literature". Some authors include pharmacological treatment and manipulations of the environment (such as marital and family therapy and involvement of friends, neighbours, professionals and agencies) in their definitions, but others describe them as being adjuncts to supportive psychotherapy. Werman (1984) suggests further auxiliary supportive measures such as support groups, work rehabilitation centres, sheltered workshops, and organizations that deal with specific problems (e.g. Alcoholics Anonymous). Crisis intervention as well as follow-up and management offered by psychiatric clinics are also referred to as supportive psychotherapy by some authors (Hartland, 1991).

The lack of clarity around what constitutes supportive psychotherapy renders unclear distinctions between supportive psychotherapy and interventions such as case management, counselling, crisis intervention, psychoeducation and rehabilitation. Holmes (1988, p.826) offers some clarity by differentiating between what he calls "non-analytical supportive therapy" (i.e. intervention in which the patient-therapist relationship serves as a vehicle for pharmacological treatment or case management) and "supportive analytical therapy" (psychotherapy in which the therapeutic relationship and content of sessions are central). However, these terms have not apparently been adopted by other authors.

With regard to structural arrangements there are areas of both consensus and disagreement. Most authors agree that flexibility of arrangements in the provision of supportive psychotherapy is essential. It is said that frequency of sessions may be anything from daily (Kaplan & Sadock, 1988) to once a year (Crown, 1988), but monthly sessions are commonly reported. Suggested length of sessions ranges from a few minutes (Kaplan & Sadock, 1988) to one hour, however sessions of 30 minutes to an hour are commonly reported. Duration of the therapy is said to be anything from one (Crown, 1988; Kaplan & Sadock, 1988) to an indefinite number of sessions. Hartland (1991) opposes some authors in stating that, by definition, supportive psychotherapy is a long-term endeavour.

Who should perform supportive psychotherapy?

The question of who might perform supportive psychotherapy remains open to debate. Mendel (1975) reports that although traditionally it is provided in clinics by psychiatrists, psychologists and social workers, he has found students of medicine and nursing, psychiatric nurses and nursing aides to be effective when appropriately instructed and supervised. According to Werman (1984, p. 49), "with good supervision, a conscientious and devoted trainee can do effective work". He adds that the therapist requires "a firm grounding in the principles of psychodynamic psychiatry", and a good working knowledge of the patient's psychodynamics. Rockland (1989) divides techniques of "psychoanalytically oriented supportive therapy" into those which do, and those which do not, require psychodynamic sophistication and skill. He does not, however, address the issues of who requires which technique, or what the expected outcome of the different levels of sophistication might be.

In the light of literature on transference and countertransference in working with severely disturbed patients, supportive psychotherapy with such patients would seem to require considerable psychodynamic understanding, self-reflection, self-awareness and control on the part of the clinician. Seriously disturbed patients may, for instance, demonstrate "rapid and stormy transference reactions" based on sexual or aggressive impulses which are poorly defended against (Werman, 1984, p. 81). According to Werman, such reactions may result in potentially destructive countertransference reactions such as intense anxiety, dislike for the patient, or impulses of retaliation. Furthermore, reactions such as unrealistic expectations of, or excessive fear of precipitating psychosis in, such patients may significantly impede psychotherapy (White & Bennett, 1981).

In brief, the debate about who should perform supportive psychotherapy remains unresolved; a situation which may be related to the varied and sometimes contradictory approaches discussed earlier.

CONCLUSION

The American and British literature reviewed has suggested that supportive psychotherapy is usually considered appropriate to the type of patient mostly served by Greenwood Hospital. It follows that this form of psychotherapy has particular relevance to this hospital. Yet, personal observation and the preliminary enquiry suggest that at Greenwood Hospital there is insufficient provision of such psychotherapy.

While the literature review highlights general problems which have implications for the practice and development of such treatment, the preliminary enquiry raises only broad problem areas specific to Greenwood Hospital. Very little is known about the detailed nature of local problems, perceptions, experiences and practices pertaining to supportive psychotherapy. Before any attempt at resolving the apparent problems can be made, and before supportive psychotherapy can be developed at the hospital, it is necessary that these areas be explored.

STUDY OBJECTIVES

This study aims to explore and document some of the expressed views, feelings, practices and problems pertaining to supportive psychotherapy at Greenwood Hospital, so that recommendations might be made towards appropriate provision of such therapy at the hospital.

Themes targeted for examination are those highlighted as problematic in the literature review and preliminary enquiry, namely:

- (1) the status of, and
- (2) feelings about performing, supportive psychotherapy,
- (3) views and feelings regarding patients with severe and persistent mental disorders,
- (4) terminology,
- (5) descriptions of supportive psychotherapy as a treatment method,
- (6) training,
- (7) referral within the hospital, and
- (8) referral to an outside (welfare) agency.

CHAPTER 2: METHODOLOGY

STUDY DESIGN

Given that the definition of supportive psychotherapy is a nebulous one, that the aim of this research is to examine broadly targeted areas, and that this study is apparently unprecedented, an exploratory, descriptive and essentially qualitative research approach is employed. The unit of analysis is individuals (Mouton & Marais, 1988).

POPULATION AND SAMPLING

Considering the various and sometimes broad definitions of supportive psychotherapy, all professionally-trained staff including trainees (subsequently referred to as clinical staff), involved in some form of psychological intervention with Greenwood Hospital patients, were considered suitable participants of the study. At the time of this study this population comprised 113 people.

In order to keep the study to a manageable size, to include members of all categories of clinical staff, and to preclude bias in selecting participants, stratified random sampling was performed. Utilizing random tables (from Kerlinger, 1986), three people were drawn from each of the eight existing categories of clinical staff: (1) clinical psychologists, (2) community-based professional nurses, (3) hospital-based professional nurses, (4) intern clinical psychologists, (5) occupational therapists, (6) psychiatric registrars, (7) psychiatrists, and (8) social workers (listed in alphabetical order). (Excluding the groups of extreme sizes, that is of the 64 hospital-based nurses and the 3 intern psychologists, each category comprised between 6 and 9 individuals).

After being provided (telephonically) with a broad and cursory description of the aim and content of the study, each person's participation in the study was requested. One person declined to participate and some of the data from two participants were lost (as a result of faulty electronics). Three additional people were therefore randomly selected. A total of 26 participants were thus included in the investigation.

PARTICIPANTS

Most (92%) of the participants had received psychiatric training at various South African institutions, and a small minority (8%) had received some training abroad. The majority (83%) of the professional nurses had trained at Greenwood Hospital, and most (70%) of the remaining participants had received (or were still receiving) psychiatric training through the affiliated university. Length of working experience at the hospital ranged from 4 months to over 20 years, the average period being 4 years. Most participants had a wide range of psychiatric experience.

DATA COLLECTION

Instrument

Type

Although a questionnaire was considered for its potential to reach all the clinical staff of the hospital, interviews were conducted for a number of reasons. In relation to a questionnaire, interviewing offers more opportunity to motivate the participant to provide relatively complete answers and it allows the researcher more freedom to probe and clarify answers. It provides more control (for example over the sequence in which questions are answered), and allows for evaluation of responses through observing non-verbal behaviour (Gorden, 1975). (Participants' non-verbal behaviour was used during interviewing as cues for probing).

Semi-structured interviews (guided by an interview schedule) were conducted, in order that both a measure of flexibility suited to a qualitative research approach, and a structure useful for focussing on predetermined themes, might be achieved.

Development

The content of the interview schedule was informed by the personal observation, preliminary enquiry, and literature reviewed in Chapter 1. Converse (1986), Downs, Smeyak and Martin (1980), Gorden (1975) and Kerlinger (1986) were drawn on to inform the design of the interview schedule, while Potter and Mulkey (1985) and Fowler and Mangione (1990) provided background information on issues about interviewing.

Pretest

The first draft of the interview schedule was pretested on seven people who had terminated their employment with Greenwood Hospital in the preceding two-year period. (This sample was targeted both because of their familiarity with, and their lack of involvement with, the hospital at the time of the study. It was hoped that the latter factor would reduce the chance of contamination of final results.) The pretest sample, chosen on the basis of availability, comprised one person from each of the eight clinical staff categories, excluding (for practical reasons) community-based professional nursing.

Following the semi-structured pretest interviews (which were audio-taped) the clarity of questions, effects of questions and my non-verbal behaviour, question sequence effects, and duration of the interview were discussed with the interviewees. At a later stage, with the help of the audio-tapes, the interview questions were evaluated in terms of what data they had elicited. The schedule was revised according to findings.

Construction

The final interview schedule (see Appendix) included closed questions which were used where specific information was sought (e.g. Question 10: "Do you understand the terms supportive therapy and supportive psychotherapy to have the same meaning?"). In contrast, open-ended questions were used to facilitate exploration and the "discovery of respondents' frames of reference" (Kerlinger, 1986, p. 443) (e.g. Question 12: "What do you understand by the term(s) supportive therapy and / or supportive psychotherapy?").

Relatively complex issues were explored through questions posed from different perspectives and with varying degrees of directness, based on the premise that "the more diffuse and less focused the method, the wider net it casts" (Kirk & Miller, 1986, p. 30). For example, expression of views regarding patients with severe and persistent mental disorders was encouraged through questions such as Question 25: "... how do you feel about working with such patients?" and "... how do you think others in your discipline feel about working with such patients?", and Question 26: "... how do you think such patients generally relate in therapy?". More oblique questions included those about ideal treatment of patients with different diagnoses (including those with severe and less severe conditions), the adequacy of therapy and services provided, and the relapse rate at the hospital (Questions 6, 7 and 8).

The schedule incorporated, in addition to details of training and work experience, the eight main, pre-determined themes listed under **STUDY OBJECTIVES** in Chapter 1.

Gathering of data

The bulk of the data was gathered by means of audio-taped interviews ranging in length from 50 minutes to 2 hours. (The length of interviews depended on factors such as participants' time constraints and the inclusiveness of their responses). Verbatim notes were taken during one interview with someone who refused tape-recording. The remaining 25 recordings were transcribed as straightforward documentation of verbal statements and exchanges, inaudible moments, and other behaviour such as laughter, sighing and clear emphasis of speech. Complex notations of inflection, pauses and other details were not considered essential to the aim of the study and were thus ignored (Levett, 1988). Together the transcripts yielded 526 pages of single-spaced, typed text.

Confidentiality of personal identity of participants was assured with respect to all forms of reporting arising from the study.

ANALYSIS AND INTERPRETATION

Analysis and interpretation were conducted in four stages:

Firstly, relative familiarity with the interview material was achieved through conducting the interviews, transcribing the tapes, and reading a cross-section of the transcripts (Potter & Wetherell, 1987).

The second stage involved categorization of the transcribed material into the eight main themes covered in the interview schedule. A "direct and rational approach" which "systematizes networks of meaning" (Levett, 1988, p. 194) was employed. Text was scrutinized and shifted into the relevant categories utilizing the outline facility of the "Microsoft Word" computer program. Where appropriate, selected text was allocated to more than one category. Relevant material preceding participants' comments was included when shifting text, in order to allow for contextual interpretation. A small amount of text, containing tangential conversation, was excluded from the outline. The organized data were printed and collated both by theme and by participant.

The third stage involved more careful examination, making sense of and "reducing" or "transforming" the data contained in the thematic categories (Miles & Huberman, 1984, p. 21). This process involved scrutiny of text for overt and covert expressions of views, factors of the interview situation influencing responses (suggested in Mouton & Marais, 1988), and comparison of findings (looking at consistency and contradiction) between and within interviews and across professional categories. Considering the complexity of language with its social functions and consequences (Harré & Van Langenhove, 1991; Potter & Wetherell, 1987) interview responses were not viewed "simply as true or false *reports* on reality ... [but] as *displays* of perspectives ..." (Silverman, 1985, p. 171).

The final outcome of the third stage included a selection of representative and illustrative examples of data, and descriptive summaries by way of narration, aggregates, percentages and diagrams. The quantification provides an overview of the "general drift of the data" and keeps the results "analytically honest" by guarding against bias in selecting and reporting data (Miles & Huberman, 1984, p. 215).

In the final stage hypotheses were developed regarding possible functions and consequences of the findings. This involved a process of inductive reasoning and re-examination of the relevant text.

ISSUES OF VALIDITY

Two measures were taken for testing internal validity. One involved the critical stance assumed in the third stage, of checking data for consistency, contradiction and contextual factors influencing responses (Miles & Huberman, 1984). The second measure was to make as much material as possible available for scrutiny, and thereby enable assessment of the analysis and the conclusions by the reader (Potter & Wetherell, 1987). (This was achieved through providing examples and explanations of hypotheses). To facilitate such an assessment the examples reported in Chapter 3 are indicated as being either illustrative of a point being made, or as representative of the data being discussed.

Regarding the issue of external validity, the relevant question is whether the findings are generalizable to the various categories of clinical staff of Greenwood Hospital. Claims of such generalizability would demand a statistically representative sample of the population. This was not attempted or considered essential to the aim of the study. Of concern, rather, was the development of some understanding of apparently complex

phenomena. The assumption underlying the method employed was that

the information derived from *any participant* is valid because that account is a product (albeit complex) of the social domain (Hollway, 1989, p. 15).

In the following chapter findings of this study are reported and discussed.

CHAPTER 3: RESULTS AND DISCUSSION

Although three categories of findings emerged, only that related specifically to supportive psychotherapy can be addressed within the spatial restriction of this dissertation. The other categories, related more specifically to systems of Greenwood Hospital and to views expressed regarding the welfare agency referred to in the study, will be documented elsewhere.

The data pertaining to supportive psychotherapy were vast in volume and complexity and might have been studied in any number of different ways. A minor dissertation of this kind is necessarily limited in its scope and cannot hope to provide a complete analysis of the wealth of material generated in this study. Recognising this limitation, the analysis was performed with the view to raising some broad issues relevant to contemporary practices and training.

Findings will be reported and discussed below in terms of the main themes set out under **STUDY OBJECTIVES** in Chapter 1 (excluding, as noted, referral to an outside welfare agency). Issues of terminology, referral and description will be presented first. These issues will be followed by a consideration of the status of supportive psychotherapy, the views and feelings expressed by participants regarding supportive psychotherapy and its patients, and training in supportive psychotherapy. A general discussion will conclude the chapter.

TERMINOLOGY

Use of terms

The majority (76%) of participants reported personal use of either the term supportive therapy (ST) (36%), supportive psychotherapy (SP) (8%), or of both terms (32%). A minority (16%) claimed non-use of either term, either because they were unfamiliar with them (a psychiatrist) or because they found no need for them in daily work (the community-based nurses). The remaining participants (8%) expressed uncertainty about whether they used the terms. These proportions are illustrated in figure 1 on the following page.

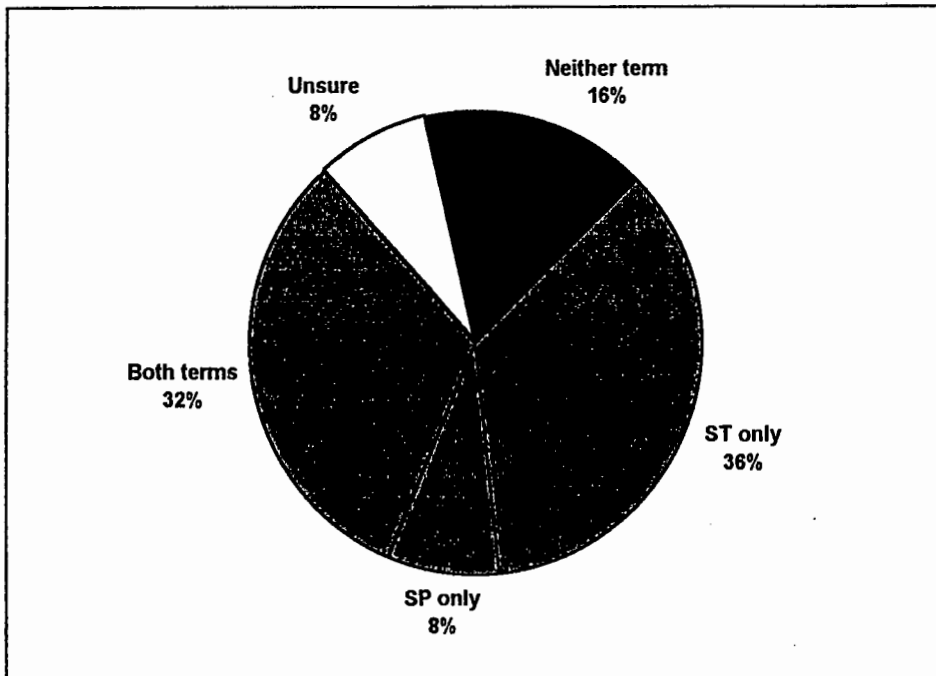


Figure 1: Reported use of terms

Reports by the psychologists confirmed that both the terms ST and SP were often used at the hospital. ST was described by one psychologist as "the buzz word" at the hospital, by another as "something that's bandied around quite a lot". A third psychologist claimed that both terms were used "more often than not" at the hospital.

Psychologists formed the only clinical staff category who said they received referrals in which the terms were used. In order to determine the volume of these referrals, the main avenue of referrals to psychologists, the out-patient referral book⁵ was examined. This check revealed that a large proportion (47%) of referrals for therapy over the preceding 15-month period specified either ST or SP, or in one case "supportive work". These referrals had been made mostly by intern psychologists and psychiatrists, but also by psychiatric registrars and one psychologist.

Given the considerable usage of the terms ST and SP at Greenwood, and indications in the preliminary enquiry of problems around definition, further attention to issues of terminology is warranted. What

⁵ At that stage referral forms for psychotherapy were not used.

follows, then, is a report and discussion of more detailed findings of this study regarding uses and understandings of terminology.

Clarity of terms

Of interest is the finding that, despite considerable use of the terms at the hospital, 50% of the participants expressed a lack of personal clarity about what the term(s)⁶ meant. This situation is not surprising, given the universal lack of clarity revealed in the literature, and added thereto the lack of any successful attempt in the literature to provide such clarity. As a number (19%) of participants indicated, the terms were inherently unclear. Two psychologists noted:

- 1) **Psychologist 1⁷:** ... it's [ST 's] not a described thing that you can say there, that's the term and if you say that term then that's what you mean ... you know, you could understand it differently to me.
- 2) **Psychologist 2:** So I don't know if it's the fault of the referring agents not really understanding what it is, or knowing what it is ... or misunderstanding it in any way... I don't think it's very, it's a very specific little type of animal, supportive therapy.

In consequence, one participant expressed a need to define, delimit and theoretically position the concept:

Psychologist 1: Well I wish somebody would at some stage start putting this together and defining it and then presenting it, giving a theoretical framework to it, and do's and don'ts and aims and things like that.

This reported lack of clarity has implications for the development of SP. Clarificatory measures which might be taken will be addressed in the general discussion below. But first a number of other issues around meaning and definition should be highlighted.

Differentiation between terms

Of further interest was the unexpected finding regarding the question of whether participants considered the terms ST and SP to have the same meaning. Despite the fact that no differentiation between the two terms

⁶ When summarising participants' responses, both the terms ST and SP will be referred to, in order to be consistent with the participants' variable usage of the terms.

⁷ Each participant will be identified by the same clinical staff category and number throughout this chapter.

(ST and SP) is found in the literature, and that some authors use the terms interchangeably (as mentioned in Chapter 1), a considerable number (42%) of participants (across six categories of staff) differentiated between the two terms. This remarkably high percentage raises a number of questions which bear consideration.

Firstly, what might have contributed towards this unanticipated finding? One possible contributing factor was that the relevant interview question prompted deliberate consideration of differences not previously apparent (an instrument effect). This possibility was suggested by a few participants, as in the following typical example:

Researcher: Do you see the terms as having the same meaning?

Psychologist 1: I think I do ... wait ... maybe I sometimes don't always mean them to be the same thing ... I think sometimes when I refer to a social worker I'm thinking of ... much more of a practically orientated type of work, and then sometimes with supportive psychotherapy ... I'm thinking this out as I'm speaking about it⁸ ... there'd be much more reflection and there would be more say of a ... Rogerian format.

A second possible contributing factor was the tendency to differentiate between the terms psychotherapy and therapy in general. This point was noted in a number of cases, for example:

1) **Intern psychologist 1 :** I would imagine that what one sees as therapy, there can be more things that are *therapy* than *psychotherapy*. So, psychotherapy I would see as the things that are informed by *theory* related to the psyche and the workings of the psyche. And supportive therapy can be crafts and art, anything that's going to sustain the person. That would be my understanding, but I don't know, I haven't read it in literature.

2) **Researcher:** Do you understand the terms supportive therapy and supportive psychotherapy to have the same meaning?

Community-based nurse 1: In my own understanding they're two different things, though I'm not quite sure about the meaning. If "psycho" then to me it would be something else. I'm not sure what it means.

Notwithstanding these possible influences, a second question to be considered below is what function(s) participants' differentiation between the terms might have served.

⁸ Underlined sections of text indicate added emphases. Italics are used to indicate participants' emphases.

One function appears to have been that of distinguishing between supportive interventions of different type and intensity. This apparent function was noted in a number of instances, as in the following typical examples:

- 1) **Psychiatrist 1:** I feel that what is generally practised is common sense, human support, and that's supportive therapy. Supportive psychotherapy ... it's in a different league ... I actually see the therapist as being much more analytic I suppose in terms of their own interaction. That I see as being careful, measured, thought out, perhaps supervised, et cetera.
- 2) **Psychiatrist 2:** Supportive therapy really is such an enormous hotch-potch, I mean virtually anything, you know, that one human being is doing to another human being in distress is supportive therapy. It is a much wider thing for me. In fact supportive psychotherapy is probably a subset within supportive therapy. Supportive psychotherapy for me would be something a bit more structured, certainly in terms of timing, regularity, frequency, a specified therapeutic alliance.
- 3) **Social worker 1:** I think [SP] would involve a deeper, more intensive work, um, clinical input [than ST].
- 4) **Occupational therapist 1:** I kind of see supportive psychotherapy as a more intense kind of interaction. Um, and supportive therapy more on a practical kind of level.

Other typical distinctions were that ST / SP is "more psychosocially and less concretely or practically orientated" (psychiatrist 1), "more emotionally supportive" (psychiatric registrar 1), and that it has, in addition to the objectives of ST, the aim of "increasing self-awareness" (psychologist 1).

However, it would appear that differentiations such as the above might have been a result of a general need to differentiate between supportive interventions, rather than a need to differentiate between ST and SP per se. For example, a number of other participants differentiated between similar interventions without distinguishing between these two terms, and indeed drew on different terminology:

- 1) **Social worker 2:** We speak about case work ... we do case work ... that includes everything, but now with therapy I don't know to what extent ... case work I suppose is therapy ... whatever we're doing, what do we call it? ... Basic things like housing, disability grants, those problems ... it's physical things that we have to do, so it's not therapy ... I wish we had another word that I could sort of choose between the two.
- 2) **Researcher:** Do you have a deliberate reason for not using the terms supportive therapy and supportive psychotherapy?

Intern psychologist 2: In a sense I do. Because I find the supportive work that I'm doing is more really a kind of a counselling than actual therapy. It's really difficult to differentiate, but ... I just felt that what I am doing is really, not really a therapy as such, I don't think that I am working through issues ... or, I'm really just providing support for them.

- 3) **Psychiatrist 4:** I do feel that, when we talk about therapy, that it's something distinct from support. I think that they are two different terms. Therapy to me does have associations with change, and a body of theoretical knowledge, or precepts. Whereas I don't see that applying to support. I see support in much more sort of human terms ... it does seem to me rather you're wrapping something up in a rather grand term - something that's, something that is a basic component of our day to day work.

It is of note that the bulk of literature reviewed in Chapter 1 does not, in contrast with the above examples, specifically draw distinctions between different types of supportive interventions. Instead, some authors use the term SP (or ST) to encompass a wide variety of supportive interventions, and terms of differentiation such as those provided by Holmes (1988) (see p.8) are not generally adopted. It seems that, through differentiating between terms, some participants provided clarity regarding differences between supportive interventions - clarity not commonly found in the literature.

Given the potential for confusion arising from the use of broad and unclear terms (as arises in the literature), participants' distinctions between ST and SP (or indeed other terms) bear further attention. An important question to be considered is whether the drawing of a distinction between ST and SP might be problematic in itself.

One might speculate that, unless there is consistent differentiation between the terms, confusion may arise. Following this hypothesis, there is potential for confusion at Greenwood Hospital. Results showed inconsistency, not only insofar as participants differentiated between the terms whereas authors reviewed did not, but also insofar as there was a lack of consensus between participants themselves. While 42% of participants differentiated between the terms, an equal proportion expressed the view that the terms were synonymous or interchangeable. A minority (16%) claimed they were unsure whether the terms had the same meaning.

In view of both the apparent clarifying function, and the possible problem, of differentiating between ST and SP, a way of distinguishing between different types of supportive interventions other than by contrasting the two terms may be worth considering. This issue will be addressed in the general discussion.

Breadth of definition

An additional source of potential confusion regarding terminology is apparent, and relates to a remarkable variation in breadth of definition of ST and SP provided by participants. ST was described broadly by those who differentiated between it and SP (e.g. as "common sense, human support" and "an enormous hotch-potch ... virtually anything"), while in contrast three participants who used the terms synonymously provided relatively tight descriptions of ST. Following are two examples:

- 1) **Psychologist 2:** ... it's an individual relationship between the therapist and client ... supportive therapy is therapy... it's important to have the container and the boundaries.
- 2) **Psychologist 3:** (When asked whether fortnightly sessions could constitute ST) ... that could fall under the term, *just*... not once... once a month I regard as doctor's appointments... just a person coming to say that I'm well, and to check things out ... moves away from *therapy*.

Furthermore, SP was defined relatively narrowly (e.g. as being "careful, measured, thought out", "more intensive" and as having a "specified therapeutic alliance") by those who differentiated between ST and SP, while, in strong contrast, a number who used the terms synonymously provided broad descriptions such as the following:

Psychiatrist 3: I see it [SP] as a generic term for any number of rituals which is usually tailored for a particular patient.

... [in addition] members of religion do it, policemen do it when they comfort victims of crime ... social workers do it, the birds and the bees do it, everyone does it ... it's even in one's ordinary interactions with friends.

Two other participants who used the terms synonymously included the support of friends in their definitions of ST and / or SP, and two included informal interactions between patients and nurses (such as having tea together or conversing in the passage).

Both inconsistency with regard to breadth of definition, as well as the use of broad definitions itself, might be implicated in problematic referrals. These possibilities will be highlighted in the following section.

REFERRAL WITHIN THE HOSPITAL

Psychologists reported three problems specifically pertaining to referrals for ST / SP within the hospital. Firstly, some referrals were said to be inappropriate in that they concerned patients unable to engage in a therapeutic alliance. Examples, reportedly drawn from personal experiences (of psychologists 1 and 2), included severely mentally handicapped and permanently psychotic patients, and a patient with entrenched, severe paranoia. Whether these referrals were inappropriate is debatable; the arguments would depend on what definitions of ST / SP were applied. It would seem that the problem with this type of referral was that the referral agents and psychologists adopted different definitions. Whereas the psychologists probably adopted relatively narrow definitions of ST / SP (as they suggested in their interviews), the referral agents might have used broad definitions which included the above categories of patients as suitable candidates. This issue suggests the importance of consistency in the use of terminology between referral agents and those receiving referrals.

The use of broad definitions of ST / SP, by referral agents, might have led to the two other problems reported. Regarding the one, referral for ST / SP seemed to fail to indicate specific therapeutic requirements:

Psychologist 2: I find we tend to get referrals for supportive therapy, it doesn't give you any idea of what you've got coming. You could have anything coming through the door, anything ... you might end up doing marital work, you might end up doing crisis work ... you might end up doing more longer-term ... you might end up doing social work.

It appears that the very option of such vague referral for ST / SP might have led to the third problem reported because it allowed for convenient, thought not necessarily appropriate, passing on of difficulties encountered by the referral agents:

Psychologist 2: Usually we're referred people who have personality disorders or psychiatric illness like schizophrenia or bipolar disorder and they're not managing. And they are referred for supportive work, whatever that might really mean. Um, they're usually people with few social resources outside, which is why they're referred to us. It's almost kind of a last ditch - what else can we do with this person - let's refer to a psychologist. I just feel that from the people I've seen coming through here this year that's often what happens.

One might speculate that both of the above types of referral could result in therapist and patient dissatisfaction as well as inefficient service provision. For example, referrals lacking in specificity do not

allow initial matching of patients' needs to therapists' interests and expertise. Furthermore, given that in the past (at least at the university affiliated to Greenwood), psychologists have not been specifically trained to deal with problems of "social resources", they may be and / or feel ill-equipped to deal with such problems effectively.

A fourth referral problem was raised which did not relate to SP directly, but which has relevance to terminological issues and to the future development of psychological services at the hospital. The following was reported:

Psychologist 2: I think that the systems of referral to psychotherapy in the hospital are also not really good ... most of all your referral sources are registrars and I don't think that they always have a very good idea of what kind of patients would be good patients for psychotherapy ... I think there are a lot of people missing out. A lot of people who could be helped - with marital therapy, family therapy, other kinds of therapies. That's often missed.

Researcher: Because people don't often have the sort of understanding to refer?

Psychologist 2: Don't have the understanding to refer, and their ... I think their idea of what therapy or what a psychologist can help with is a bit narrow.

It would seem that an underlying problem might have been that referral agents were not sufficiently aware of what treatment options were available at the hospital. This issue, as well as those referral issues noted above, will be re-addressed in the general discussion.

But first an outline and discussion of further details provided by participants, in describing SP as a treatment method, will be provided.

DESCRIPTIONS OF SUPPORTIVE THERAPY / PSYCHOTHERAPY AS A TREATMENT METHOD

What will be traced throughout this section are points of agreement in participants' descriptions of a form of psychotherapy which, like that in the literature, differed from the traditional insight-oriented model. In addition, areas of inconsistency, which have implications for the development of SP, will be highlighted. Some of the findings will be considered in terms of possible consequences. For the most part, because of space restriction, only the more commonly reported descriptions are documented below.

Selection criteria

The selection criteria for ST / SP put forward by participants generally corresponded with the literature and included factors often considered contra-indicated for insight-oriented therapy. In addition to describing suitable patients as those who suffered from any of many psychiatric conditions, including "neuroses" (suggested by 33% of participants), or those who were motivated or willing to engage in ST / SP (29%), a number of participants indicated that the following patients were suitable for ST / SP: those who lacked the psychological resources necessary for engaging in insight-oriented therapy (25%); those who had "limited ego resources" or fragility (25%); those who suffered from persistent illnesses such as schizophrenia and bipolar affective disorder (25%); and patients who were psychotic (25%).

Goals and aims

Participants' suggested goals and aims of ST / SP similarly corresponded with the literature, describing a form of treatment which, unlike insight-oriented therapy, was not aimed at personality re-construction. Objectives most commonly reported included those of providing emotional support (suggested by 21% of participants), improving functioning (21%), developing "coping skills" (13%), improving the patient's condition longitudinally or preventing relapses (13%), "teach[ing]" (e.g. about medication and psychiatric illness) (13%), providing "containment" (13%), and promoting the use of adaptive "defences" (13%).

Theoretical frameworks

In support of Crown's (1988) stated view, almost half (46%) of the participants said that a variety of theories could be drawn upon in order to perform ST / SP. Theories suggested as being potentially useful included "psychodynamic" or "psychoanalytic" (suggested by 29% of participants), "cognitive" (17%), "Rogerian" (13%), "developmental" (8%), "humanistic" (8%), "social learning" (8%), "behavioural" (1 participant / 4%), "cognitive-behavioural" (4%), "family systems" (4%), and "interpersonal" (4%).

In contrast to a group of authors who assert that a psychodynamic framework is essential, psychodynamic theory was suggested by only one participant (an intern psychologist) as being necessary to SP. Furthermore, on a number of occasions psychodynamic "work", "therapy" or "psychotherapy" was

associated specifically with reconstructive or insight-oriented therapy and / or was contrasted with ST / SP.

For example, psychologist 1 said that

... there's a narcissism involved with psychodynamic therapy ... the plebs can do the supportive work.⁹

Rockland (1989) has pointed out that this practice is a common error, since psychodynamic theory is as appropriately applied to insight-oriented therapy as it is to SP (see quote on p. 7).

A number (21%) of participants (psychiatric registrar 2, occupational therapist 2, hospital-based nurse 1, and community-based nurses 1 and 2) expressed an inability to answer questions on theoretical framework because of a lack of knowledge. Others (17%; occupational therapists 3 and 4, hospital-based nurse 2, and community-based nurse 3) suggested that the work did not require knowledge of any theory.

The possible consequences of this clear lack of a unanimously held, specific theoretical framework, will be considered below.

The following contradictory argument suggests that, at least for one participant, a consequence might have been a decrease in the strength of SP's position as a psychotherapy, and a reduction in its status to something other than a recognized, "formal" psychotherapy:

Psychiatrist 2: Ya, for me psychotherapy is any formal, it's any regular, structured, um, psychotherapeutic intervention using a recognized formal theoretical underpinning.

Researcher: Alright. But you exclude supportive psychotherapy in that, in your understanding.

Psychiatrist 2: No, well, (sigh), ya. I don't exclude it but I wouldn't call it, I would probably differentiate between supportive psychotherapy and formal psychotherapy. But formal psychotherapy is anything that you're doing specifically, from behavioural through to psychodynamic.

The same psychiatrist and a psychologist indicated a second possible consequence - that is, reduced comfort or confidence in performing ST / SP:

- 1) **Psychiatrist 2:** [Supportive] psychotherapy I'm comfortable with doing, but less comfortable than with doing a more specific form of therapy like cognitive therapy

⁹ There are two further examples in quotes provided for other purposes. See the relevant texts, marked with asterisks, on pages 31 and 37.

... I think any therapist if they're honest is most comfortable dealing with familiar territory - working with their model, with their full-on theoretical model. Because I think - supportive psychotherapy you're always to an extent treading unknown ground.

- 2) **Psychologist 2:** You know I think that ... something that makes it easier to feel more clear about insight-oriented therapy is that it's really very much more part of my training - it's cognitively very much more in our training. I don't think that *practically* we get any more training in insight-oriented therapy in the end, but we've grown up with insight oriented therapy. We read it ... there are lots of books from different theoretical viewpoints ... there's a theoretical containment for it ... there's a much broader container, much more extensive as well. Supportive therapy is something that I certainly haven't seen as much written about. I haven't read as much about. It seems very much more in an exploratory stage as far as the theory goes - and I think *that* is partly what makes me feel that I know a bit more about insight-oriented therapy than supportive therapy, although I've *probably done* more supportive therapy than I've done real insight-oriented therapy at this stage of my career.

Researcher: And how confident do you feel in performing supportive therapy?

Psychologist 2: *Not very* confident. I don't feel that I really have, um, cognitive - theoretically something to hang on to.

Researcher: ...how confident do you feel in doing that insight-orientated psychodynamic therapy?

Psychologist 2: I would feel slightly more confident. Slightly more confident. And again, maybe because of the kind of training, the theory that is behind it.

A third possible consequence was raised by the above comment of the psychiatrist and reinforced by several others. While the psychiatrist suggested that SP did not draw on a "full-on theoretical model", others described it, for example, as being therapy in which a "mild psychodynamic type of looking at patterns or at the past" (psychologist 1) might be used, and as a "watered-down eclectic approach" (psychiatric registrar 3). Such references to the theoretical framework of SP as attenuated or diluted may well have a negative impact on the quality of practice and the status of SP.

The possible consequences of the lack of a unanimously held, specific theoretical framework will receive further attention in the general discussion.

Clinical format, principles and techniques

Corresponding with the literature, ST / SP in a clinical setting was commonly described by participants in terms of a dyadic interaction. In contrast, however, the occupational therapists generally described it in

terms of a group format. Such inconsistency, whilst probably a result of different training programmes and foci, nevertheless could be an additional source of confusion amongst clinical staff.

Reported principles and techniques similarly corresponded with the literature. Those most frequently suggested included listening (suggested by 33% of participants), problem-solving (25%), reflection (21%), guiding and directing (17%), empathy (13%), a Rogerian approach (13%), helping the patient use personal strengths (13%), and interpretation (13%). Those who suggested interpretation added the condition that it should be used "sparingly" and with "caution".

Consistent with the lack of agreement in the literature, participants differed as to whether they included various interventions in their definitions of ST / SP. These interventions included pharmacological therapy, the brief, out-patient follow-up traditionally provided by psychiatric registrars and psychiatrists, the various occupational therapy activities, group therapy, family therapy, crisis intervention, counselling, and case management. (These findings were incidental rather than sought systematically for the whole sample, and are thus not convertible to meaningful percentages).

Some similarities as well as marked differences in opinion were expressed with respect to structural arrangements. With regard to the duration of treatment, none of the participants concurred with the view put forward by Hartland (1991), that ST / SP was necessarily a long-term endeavour. Twenty percent emphasized that ST / SP was necessarily of short duration (maximum of weeks or months), while the rest adopted a more flexible position. The latter said that the duration could be either long or short. Where a short duration was suggested, some said that the therapy could occur in a one-off session, whereas others indicated that one session did not constitute ST / SP and stipulated a period of weeks or months. Those indicating a long duration referred to years or an indefinite period.

It was generally suggested that the length of sessions would usually be between 30 or 45 minutes and an hour. A number (36%) indicated that under certain circumstances (e.g. when the patient was psychotic or severely disturbed) sessions could be brief, such as three or 10 minutes. In contrast, two participants (8%) stated an "absolute minimum" of 30 minutes.

In keeping with the literature, it was commonly suggested that with ST / SP, therapists needed to be flexible with regard to structural arrangements. Frequencies ranging from daily sessions (e.g. during crises) (12%) to six-monthly sessions (one participant; 4%) were reported as being possible, whereas weekly sessions were referred to most commonly (48%). Different opinions regarding minimum frequency at the outset were expressed. One participant stipulated an initial minimum of three times a week, two stated once a week, while another said that once a month was feasible initially. Contrary to other statements, one person (psychiatrist 1) said that more than once-weekly sessions would be too intensive to be considered ST / SP.

Who should perform supportive therapy / psychotherapy

It was commonly suggested that people from all categories of clinical staff who were interested and adequately trained should be able to perform ST / SP. (Information which would enable comparison of this finding with related views regarding insight-oriented therapy was not sought).

The majority (74%) of comments with respect to the question of skill required to perform supportive and insight-oriented therapies supported the idea that these therapies were different. Almost half (44%) of the participants said that ST / SP required less skill to perform than did insight-oriented therapy; some (22%) suggested that the skills required could not be compared in terms of more or less, but that they were different; others (8%) suggested that ST / SP required more skill to perform because, in contrast to insight-oriented therapy, it lacked specific theoretical backing. (The remaining 26% said that both therapies required an equal amount of skill to perform).

Descriptions in terms of insight-oriented therapy

A tendency among certain participants to define ST / SP in terms of insight-oriented therapy bears consideration, since such an approach may have implications for the status of SP.

Rather than defining ST / SP in its own right, some participants described it in terms of insight-oriented therapy. (In some cases such comparative description might have been prompted by an earlier question which raised the topic of insight-oriented therapy. However, in other instances such a possible instrument effect was not suggested, in that participants provided comparative descriptions prior to this topic having been raised by the researcher.) Typical comparative examples were that SP was "a little more directive, a

little more containing and more issue or problem-oriented" (psychiatrist 3) and "more supportive" (psychologist 3).

Furthermore, two psychologists indicated that they defined assessment criteria for ST (called "supportive work" by one psychologist) in terms of insight-oriented therapy (or "long-term work"). (One psychologist also claimed to define the criteria in terms of "crisis work".) They reported the following:

- 1) **Psychologist 2:** When I assess somebody for supportive work, what I'm realizing is, generally now, is that a lot of the time it's almost like your assessment for supportive work comes ... after other things have been excluded. I would assess somebody and then assess them as not suitable for long-term work because ... it's not what they're expecting from therapy, because they haven't got the motivation for it, or the resources for it. And I would assess somebody for more crisis work you know, find that they actually don't quite need that, and in a way that's where I would end up doing more supportive work. It's almost as if - I'm just really kind of realizing it now, that it's almost like when you exclude everyone from the other categories, you end up with supportive work ... But I can't think of anything that would specifically indicate for supportive therapy, that I could specifically latch on to it and say - because that is present, I would do support work. It's rather, because these things are absent I would do supportive work.
- 2) * **Psychologist 3:** I've answered the question what factors I looked at to see that the person is *not* suitable for, um, insight-orientated, but not suitable for supportive therapy ... I think it's the general, basic thing that I look at. That they're not suitable for psychodynamic then I seem to consider supportive therapy.

One might speculate that such definition of ST / SP, in terms of insight-oriented therapy (and "crisis work"), may perpetuate a diminished status of SP rather than validate it as a form of treatment in its own right.

This point brings us to the question of the apparent status of SP at Greenwood Hospital.

STATUS OF SUPPORTIVE THERAPY / PSYCHOTHERAPY

The status of ST / SP at the hospital was reported by the majority (63%) of participants to be low, in keeping with literature documenting earlier views of SP but in contrast with later views which indicate an elevated status (discussed in Chapter 1). Many participants stated that it was viewed by hospital staff as being inferior to insight-oriented therapy. Typical comments were that ST / SP was a "very much maligned and under-rated activity" (psychiatrist 2), "a poor relation to insight therapy" (psychologist 2), and an approach about which clinicians did not have "any awareness" (psychiatrist 3).

Some participants claimed that, in contrast, insight-oriented therapy was generally viewed as, for example, "much more exciting and grander and specialized" (psychiatrist 4), "intellectually superior" (psychologist 1), "more thrilling" (psychologist 2), and as a form of therapy about which people were "slightly awestruck" (psychiatric registrar 2). Associated prestige was suggested, as in the following typical example:

Psychiatrist 3: (In answer to a question of how much status ST / SP has as the hospital): When it comes to standing out in the crowd, saying I am a - , I think the majority would say I am a psychodynamic psychiatrist or whatever it is.

It is noteworthy that participants indicated psychologists as the staff category most likely to perceive ST / SP as inferior to insight-oriented therapy.

In contrast to the above findings, two hospital-based nurses (1 and 2) expressed the opinion that the status of ST / SP was high, and an intern psychologist (3) indicated that amongst nurses its status appeared to be high. The remaining participants (psychiatric registrar 1, hospital-based nurse 3 and all the community-based nurses) said that they were unsure of its status.

Although participants did not explicitly acknowledge holding negative views of ST / SP themselves, a close analysis suggests a contrary situation. Negative inferences arose in comparative and contrasting accounts of ST / SP and insight-oriented therapy. For example, it was suggested that movement from insight-oriented to supportive psychotherapy represented a lowering in quality of therapy. In the following extract a psychiatrist referred to this movement as downgrading:

Psychiatrist 2: ... and even supportive *psychotherapy* I think merges into other forms of therapy for instance you can sometimes start out with wanting to do, um, fairly long-term orthodox psychodynamic work and then find that the patient can't tolerate the anxiety induced or doesn't have the ego strength or whatever. And then in fact will downgrade your therapy to a more supportive, less intense type of work. And I think there can be a lot of shades in-between those.

A second psychiatrist's statement implied that the usefulness of ST was unexpected. This implication was suggested in the qualification introduced by the conjunction "but" in the last sentence:

Psychiatrist 1: But I think post-psychosis, we tend to teach the students to be cautious with individual therapy. But take for example - (name of therapist who is

known to work with severely mentally ill patients), I think in a select case it can be very useful. It's probably a supportive type of therapy but it can be useful.

In other instances ST / SP was compared with insight-oriented therapy with the latter therapy being described as "real" in some way. These comments seemed to imply that ST / SP was inferior. What was suggested in the following example was that supportive work did not constitute proper psychodynamic work:

Psychologist 1: Some of them were sent for I'd say like real psychodynamic type of work and others were sent for um ... again what I would think of more as supportive fashion - where we thought there wasn't, there wasn't going to be more, much more than what has happened. They just need somebody to be there for them.

In another excerpt, what seemed to be implied was that insight-oriented therapy produced "real" and "dramatic" changes whereas ST did not:

Researcher: So your preference would be for insight-oriented, would you say?

Psychologist 2: Not necessarily ... one can help somebody just as much with supportive therapy as with real life-changes, dramatic stuff.

The suggestion was also made that "psychological things" were the stuff of insight-oriented therapy whereas SP did not deal with such phenomena:

Psychologist 2: You know, there's always the attraction of doing long-term work, or more insight-oriented work ... be it long or short term. Which I think is what happened with this girl. I wanted ... the links were so lovely and they were so clear. I would have liked her to do what I wanted her to do. So I think there's always the attraction of going for the insight - going for the interesting connections and the interesting details. But - I really feel that, um, that it's important for me as a therapist to be aware that not everybody has the interest that I have in psychological things. And that a lot of people are still quite frightened by that. And it's important to respect somebody else's need not to go into that. And that that is useful for people. I don't think that as a therapist we should have to go in and change people's lives - that is often what is so much more tempting to do. So ... the answer in short is ya - although, although I find other, you know, insight stuff more exciting, I feel that this [SP] is important. As important if not more important to do kind of supportive work.

A further implication here appeared to be that "chang[ing] people's lives" was achieved through gaining insight and not through SP.

Suggestions either of inferior status or prestige, such as those cited in the above examples, raise the question of participants' views and feelings about performing SP. This question is addressed in the following section.

FEELINGS ABOUT PERFORMING SUPPORTIVE THERAPY / PSYCHOTHERAPY

Occupational therapists and nurses (both hospital- and community-based), whose job descriptions did not include individual psychotherapy or case management, generally expressed satisfaction with doing the supportive work they did, that is, mostly group work and informal support of patients respectively. Five of them (56%) elaborated, saying that they derived satisfaction from the work because of its usefulness to patients.

The remaining participants reported either a lack of negative feeling, or some degree of positive feeling, about performing (individual) ST / SP. Comments were more or less evenly spread along a continuum of degree of enthusiasm expressed. Typical unenthusiastic responses were "I don't resent doing it", "I don't have a problem with it", and "it's just another tool I use". More enthusiastic responses included "I'm happy to do it" and "I enjoy it".

Half of those who expressed positive feelings about performing individual ST / SP explained these feelings in terms of the work being necessary or helpful to patients. Others explained their positive feelings in terms of the work reducing readmissions, a sense of relative confidence in performing ST / SP, the (perceived) short-term nature of the work, or the opportunity it provided therapists for being practical and productive. One participant said that he enjoyed SP because, unlike the prescription of medication, it afforded the opportunity to interact with, and express empathy towards, patients. Descriptions associated with insight-oriented psychotherapy such as "thrilling" and "exciting" (referred to earlier) were notably lacking.

In spite of the reported positive feelings about performing ST / SP, only two participants (a psychiatric registrar and social worker),¹⁰ other than the nurses and occupational therapists, claimed to prefer ST / SP above other psychotherapies. In contrast, four participants (a psychologist, two intern psychologists and a psychiatric registrar) said that their preference was to perform insight-oriented therapy. Other reported preferences included case management (psychiatrist), cognitive therapy (psychiatrist), family and group therapy (social worker), "a combination of dynamic and cognitive therapy" (intern psychologist), strategic therapy (psychologist), and a broad repertoire of therapies (social worker and psychologist). (Two

¹⁰ Participant numbers are omitted in this and the following two paragraphs in order to preserve confidentiality. In some cases the treatment preferences are well known to other members of the hospital staff.

psychiatric registrars said they felt too inexperienced to state a preference, and a psychiatrist said that he preferred not to perform psychotherapy).

The fact that, of the participants whose job descriptions included individual intervention, so few reported ST / SP to be their preference, bears consideration. It might be argued that attempts at developing SP at the hospital (which, as was suggested in Chapter 1, appears indicated) would be ineffective if SP falls very short of providing clinicians with the satisfaction they gain from their preferred psychotherapies. Following this argument, knowledge of what it is about their preferred psychotherapies which clinicians find satisfying, is essential to gauging the feasibility of developing SP. Equally, such knowledge is important in effective planning of the therapy.

Participants were therefore asked to provide their reasons for preferring a particular psychotherapy. Various explanations were given: feeling competent in doing the work (the four psychiatrists, referring to different interventions); believing that the "benefit of [the] therapy outweigh[ed] the risks and ... [was] worth the input" (psychiatrist referring to case management); being able to be practical and productive (social worker, referring to SP) , and to interact with, and express empathy towards, patients (psychiatric registrar, referring to SP); having the opportunity to be active and to achieve rapid results (intern psychologist and psychiatrist referring to cognitive therapy); feeling liberated (psychiatrist, referring to cognitive therapy not "bogged down by analytical dogma"); and being able to be creative and flexible (psychologist with reference to strategic therapy). The combined reasons given by those who indicated that insight-oriented therapy was their preference were that it was challenging, allowed intellectual and emotional growth of the patient and therapist, and it enabled the therapist to "use [his / her] brain" and to work intensively and symbolically.

Given these findings, one might surmise that, with certain changes, many of the perceived advantages of performing the various preferred therapies could become associated with SP. For example, with more training therapists might feel a greater sense of competence in performing SP. Further, more positive views of SP could be created. Considering the descriptions of ST / SP provided by contemporary authors and some participants in this study, SP may well become associated with the sorts of attractions the participants associated with their preferred therapies. These features include therapist activity, creativity and flexibility, as well as challenge, intellectual stimulation, "use [of the] brain", and intellectual and emotional growth of

the patient and therapist. Ways in which some of these factors could become more strongly associated with SP at Greenwood will be considered in the general discussion.

As was discussed in Chapter 1, clinicians' views and feelings regarding patients with severe and persistent mental disorders are also relevant to the effective development of SP. These issues therefore receive attention below.

VIEWS AND FEELINGS REGARDING PATIENTS WITH SEVERE AND PERSISTENT MENTAL DISORDERS

In contrast to what was reported in the literature, participants' views expressed about this patient population as a whole were generally positive. On questioning, the majority expressed difficulty in generalizing about such patients' ability to engage in a therapeutic alliance, but indicated that certainly some were capable of relating adequately. Furthermore, in contrast to Pedder's (1991) finding, a large majority expressed the view that these patients were not particularly dependent. Many added that those with "neuroses" were often more dependent than those with psychoses.

When asked how they felt about working with such patients, almost half (46%) of the participants expressed positive feelings. Responses included those such as "I love working with them" and "I'm quite comfortable". Four (15%) assumed a neutral position (e.g. "I don't have a problem"). An additional six (23%) indicated a sense of duty or of resignation (e.g. "we have to", "it's the nature of our work ... so you accept that", "it's a fact of life"). Four (15%) reported both positive and negative feelings (e.g. "They're very challenging but ... it can be frustrating"). One emphatically expressed displeasure at working with such patients ("I don't enjoy it ... fullstop").

Although the majority of participants claimed that they were themselves positively or neutrally disposed towards working with this patient population, some indicated that a number of other clinicians felt negatively. The following, for example, was stated:

Psychologist 1: ... you just know the chances of selling a patient that's got long-term schizophrenia to a person in private practice is practically nil.

Researcher: And here, selling a patient?

Psychologist 1: Depends on how you sell him.

Researcher: You mean, if you give all the information or not?

Psychologist 1: Yes, and how much you ... yes, it depends on the manipulateness of the therapist that's doing the referral.

In addition, negative views were, again, attributed to clinicians with a relatively strong interest in "therapy" or "psychodynamic" (insight-oriented) work. A psychiatrist stated:

Psychiatrist 2: I think *many people* often don't like working with them and I think it must be said that the non-medical members of the mental health team are often the biggest culprits. Psychologists, social workers, nurses, often *much* prefer to do more therapeutic, so-called therapy work than deal with these relapsing, chronic patients. Um, which are often seen as less stimulating, less challenging, less to be able to do. Doctors are often more receptive to dealing with these patients, but I think partly, not because of any greater nobility at all, but because a lot of these patients' treatment is biological. Which only doctors essentially can do. So I think part of it is just because of your areas of interest.

The following two excerpts, which refer to psychologists attracted to "psychodynamic work", support this comment:

1) **Researcher:** How do you think others in psychology feel about working with such patients?

Psychologist 1: No, generally I think mostly people don't clamor - they're not clamoring to work with them ... they're not queueing.

Researcher: Do you have any idea why?

* **Psychologist 1:** Because of this way that psycho - reconstructive therapy or psychodynamic therapy is seen as intellectually superior ...

2) **Researcher:** ... I was wondering how you feel other psychologists feel about working with these patients.

Psychologist 3 (referring to working with psychotic patients): ... I've come across *a few* people who said that they find it challenging. I think most people find it daunting, you know overworking and really not stimulating because they can't do the dynamic stuff. And I just have come across those types of comments at times. So that makes me feel that maybe some psychologists don't find this kind of work ... fascinating.

Researcher: Would you say that's the majority, in your experience?

Psychologist 3: I haven't come across, Mona, a lot of people who rave about working with psychotic patients.

Researcher: Have you heard people raving about psychodynamic ...

Psychologist 3: I've heard lots of people, I hear a lot of rave about (specific unit providing psychodynamic treatment in a milieu setting), than I hear a lot of rave about Greenwood.

Findings pertaining to patients with severe personality disorders (which represent one of the main categories of patients with severe and persistent mental disorders) have important implications for the development of training programs. It is useful, therefore, to consider the views expressed by participants regarding this patient population.

There appeared to be a sense of uncertainty and uneasiness around treatment of patients with severe personality disorders. The question about ideal treatment of such patients was commonly met with laughter or with comments such as "that's a difficult one"; some (25%) expressed an inability to answer the question. The majority (62%) suggested that some form of intervention might be helpful, but many expressed uncertainty about what this intervention might be. A few (13%) suggested that there is no treatment for such patients.

It is of further interest that, of the many types of personality disorder, a number of people singled out "borderlines" as being potential psychotherapy candidates, and one participant said that these were patients he had "much more time for". Reasons were not provided, but one might speculate that the great deal of attention paid to this patient population in recent literature (Stone, 1986) might have resulted in increased confidence in working with this patient group and therefore in relatively positive responses. This hypothesis has relevance for future training and will be addressed in the general discussion.

A few people attributed negative attitudes towards patients with severe personality disorders to other staff members. A psychiatric registrar, for example, in response to the question of how others seemed to feel about working with patients with severe, relapsing illnesses, responded as follows:

Psychiatric registrar 3: I think that a lot of them find it frustrating ... and so you slip into labelling patients ... and patients then often get labelled on Axis II, and they get written off for further ... the potential for further intervention because of that.

In response to the question about ideal treatment of people with severe personality disorders, the same registrar said that most hospital staff were probably working on the "assumption" of the affiliated university,

which is that "severe personality disorder" means "people you throw out the door ... don't even let in the door!".

The preceding sections have highlighted a number of points regarding practices, views and feelings which may have implications for the future provision of SP. It would seem that training may play an important role in shaping these factors.

TRAINING

Most participants indicated that they had not received formal training in ST / SP (e.g. it was learned through "osmosis" (intern psychologist 1)), and / or that it was not taught as an entity in itself. In the words of a psychologist:

Psychologist 1: There was never a model given to it, never a term, it was never defined, discussed as an entity by itself.

Thirty-one percent (all the clinical and intern psychologists and psychiatrists 1 and 3) expressed the opinion that clinicians' training should include ST / SP. Some reasoned that this training was indicated since the therapy and / or the term ST / SP was prevalent at the hospital. For example:

- 1) **Psychiatrist 3:** Just thinking about it now, the great majority of our work is supportive, in actual fact. That's the de facto situation, and given that, we should be given a disproportionately higher amount of training in supportive psychotherapy. I mean that's logical.
- 2) **Psychologist 3:** I think since we use the word so glibly and so much ... I would say that because of the fact that in the hospital system we talk about that word more often than not, that maybe there needs to be much more clarity from the training position.

All but one (of the 31%) specified that the training should develop conceptual or "cognitive" clarity.

A number (24%) of participants, across five categories of staff, stressed the importance of training in ST / SP including the teaching of practical strategies or "techniques".

Although a number of the participants argued that, for practical and logical reasons, ST / SP should be included in training, a psychologist cautioned that trainees' attitudes would need to be considered should ST be introduced or receive more emphasis in training:

Researcher: I guess what I was thinking when I asked you the question - you said 20% to 30% [of the course on therapy should be allocated to supportive therapy and supportive psychotherapy] ... I was wondering how much, what percentage would reconstructive therapy get, if you were making that division in your mind?

Psychologist 1: I don't think that many people want to do this thing called supportive therapy, and I think it would be dangerous to bring it in as a whole, give it equivalent status ... it could actually be counter-productive.

If teaching institutions should consider including SP in psychotherapy courses (as some of the participants suggested), another report of a psychologist, which raises the issue of relevant experience in training, bears consideration. It would seem that this psychologist's internship provided more experience of pharmacological than psychological treatment of patients with psychotic conditions. The explanation provided for having minimal, "a bit more" and "very much more" confidence in assessing patients for supportive, insight-oriented and pharmacological therapies respectively, was the following:

Psychologist 2: I think because of my training, my experience has been mostly in acute psychotic and chronic psychotic, with psychotic patients. Most of my internship was in that.

This report highlights the importance of teachers ensuring that trainee psychotherapists gain appropriate experience. Training which includes SP might usefully provide trainees with the experience of assessment and psychological treatment of a variety of patients, including those with severe conditions such as psychoses.

In addition to possibly gaining confidence through such experiences, a further consequence could be a change in trainees' opinions of SP. A clinical psychologist (1) described how performing SP resulted in a change of view, from "looking down" on it to valuing its importance; an intern psychologist, who had some practical experience of SP, stated the following:

Intern psychologist 1: I feel fine with it [SP]. I think it's very useful. I think when I started my training I wouldn't have thought so. But I'm seeing more and more that it's very useful.

Based on these two reports, it would seem that appropriate inclusion of SP in training may positively influence trainees' views of SP.

What bears further thought, however, is how training, and possibly other interventions, might develop a view of SP, not only as "useful", but also as "challenging", "exciting" and "stimulating" - adjectives mostly associated with insight-oriented therapy. This question will be addressed in the general discussion which follows.

GENERAL DISCUSSION

In keeping with the literature, participants described a form of psychotherapy which differed from the traditional, insight-oriented psychodynamic model. The majority claimed to use either or both of the terms ST and SP for such treatment.

Amidst calls by some authors (e.g. Hartland, 1991; Werman, 1984) and participants in this study, to promote the understanding and / or practice of SP, a number of possible obstacles to furthering its development were highlighted by this study. These problems included a lack of clarity and consistency regarding terminology, description and theoretical framework, and, despite attempts in recent literature to boost its status and attractiveness, an attribution of low status and limited therapist satisfaction to SP. Some referrals for ST / SP were furthermore described as problematic.

The question of solutions to these problems is a complex one. Some of the literature reviewed in Chapter 1, as well as some of the participants in this study, suggested that the answer might lie in increased research, literature and / or training in SP. However, this study raises issues and questions which challenge the viability of these solutions. These points will be discussed below.

An important question, prompted by participant responses, is whether SP can be developed conceptually, practically, and in terms of status, when it lacks a unanimously held, specific theoretical framework. Findings suggest that this development may not be possible, given that such a lack could result in reduced status of SP as a psychotherapy, a lack of therapist confidence and comfort in performing it, and a lack of theoretically informed treatment (or treatment which has an attenuated or diluted theoretical basis).

A solution, then, might appear to be an attempt at developing a unanimously held, specific theoretical framework. A question which arises, though, is whether adaptation to patients not suited to traditional techniques necessitates establishment of a "different" psychotherapy - one with a different theoretical

framework and name. Can existing "formal" therapies such as psychodynamic psychotherapy not include models suited to a broader patient population? (The term psychodynamic psychotherapy in this sense is used broadly, referring to therapy which has its roots in psychodynamic theory (Mischel, 1993).) Literature which compares insight-oriented and supportive psychotherapy suggests that inclusion of these therapies under one descriptive category may well be appropriate. Some authors indicate that the goals and strategies of these therapies are on a continuum (rather than mutually exclusive), and others suggest fluidity between, and overlapping of, the respective techniques (referred to in Chapter 1).

It would seem that with the development of object relations theory and therapy a move is already being made in the direction of "formal" therapy (in this case psychodynamic psychotherapy) incorporating models for a wider patient population (see for example Cornett, 1991). It might be argued that cognitive psychotherapy is another "formal" therapy which can be expanded to accommodate a broad patient population.

Findings of the present study suggest that if psychotherapy which departs from the traditional insight-oriented model were to be incorporated conceptually and terminologically into "formal" psychotherapy categories, and the terms ST and SP were to be discarded, a number of potential obstacles raised by this study might be overcome. Firstly, psychotherapists may feel more confident and be more effective if guided by an established theoretical framework. Secondly, if affiliated to respected theory (rather than being contrasted to such), this form of psychotherapy may stand more chance of shedding the stigma of being less prestigious. Thirdly, if informed by recognized theory, such therapy may provide intellectual stimulation and challenge. Fourthly, the possibility of confusion arising from terms (ST and SP) which are unclear and used inconsistently, may be avoided.

A further advantage might be that the terminological problems raised in Chapter 1 (e.g. that the term SP incorrectly implies exclusive use of supportive techniques and may result in therapists losing interest in, and alertness to, important communications) may be avoided. Finally, rather than being viewed as a separate concern, it would seem that research into, and literature about, such psychotherapy may supplement and enrich that which already exists with respect to "formal" psychotherapies.

Notwithstanding possible advantages of incorporating SP into "formal" categories, the apparent clarificatory value of some of the participants' differentiation between terms such as ST and SP bears consideration. It

will be recalled that a function of such terminological differentiation appeared to be a differentiation between various interventions.

Within the framework of "formal" categories suggested above, there are a number of ways in which clarificatory differentiation between interventions can be retained. Firstly, Rockland's (1989, p. 452) approach might be adopted, and all psychoanalytically or psychodynamically oriented psychotherapies might be viewed as containing mixtures of supportive and exploratory interventions and might, when applicable, be described as consisting of "primarily supportive" or "primarily exploratory" (or insight-oriented) modalities. Secondly, specific interventions based on other recognised models and / or theories might consistently be recognized and referred to as separate entities. In other words, instead of these interventions being included under broad terms (such as was the case with broad use of the terms ST and SP), their respective terms might be used when applicable. For example, the following might be specified: case management (see Bachrach, 1984 and Geller, 1989 for definitions); counselling (see Brammer & Shostrom, 1977); crisis intervention (see Mendel, 1975); pharmacotherapy (see Liberman & Phipps, 1987); psychoeducation (see Barter, 1984); psychosocial rehabilitation and one of its components, skill teaching / development (or skills training according to occupational therapists in this study) (Dion, 1989). Thirdly, supportive interventions not necessarily based on established theories or models (e.g. support provided by families and spontaneous conversations held in hospital corridors) might usefully be termed support, as suggested by some participants of this study.

Additional clarity might be achieved through careful use of the terms therapy and psychotherapy. A finding of this study was that some participants contrasted these two terms and attributed a tighter definition to the latter. For this reason, when an intention is to convey in communications the fact that an intervention is structured and informed by psychological theory, the term psychotherapy might be useful.

Regardless of what terms are applied, Werman's (1984) contention (see quote on p.6) that there are substantial differences between supportive and insight-oriented aims and techniques, should be borne in mind. His assertion reminds us that the need for developing and promoting appropriate therapeutic models, other than the traditional insight-oriented psychodynamic one, remains. Relevant training would seem essential to such developments.

With respect to training, it appears important that trainee psychotherapists be taught, and sufficiently exposed to, assessment and treatment with regard to a wide range of psychotherapeutic models and patient difficulties. Instead, in the past, training of intern psychologists at the university affiliated to Greenwood Hospital, in individual, adult psychotherapy, was specifically in assessment for, and execution of, insight-oriented therapy (otherwise loosely and often incorrectly referred to as "psychodynamic" or "long-term" therapy) (Dickman, 1983; Kottler, 1991) with relatively healthy individuals.¹¹ Furthermore, as was mentioned earlier, a participant in this study reported more training in pharmacological than in psychological treatment of psychotic patients during the clinical psychology internship. Careful planning of trainees' exposure to various psychotherapeutic experiences therefore appears essential. In addition to this planning, a particular attitudinal approach by teachers would seem important:

... targeting the chronic mentally ill population as a primary object of care rather than seeing it as undesirable or consisting of "second-rate teaching cases" (Talbot, 1987, p. 15).

The suggestion of one participant, that SP not be given equal weighting in training programs, because of its lack of popularity, bears mention. It would seem that, if SP were no longer considered a separate entity (as proposed above), this concern with lack of popularity might be less relevant. Instead of being taught SP, trainees could learn both "primarily supportive" and "primarily exploratory" goals and therapeutic strategies, with the understanding that, as suggested by the following statement, they have equal importance:

All psychotherapies are mixtures of supportive and exploratory interventions To quote Knight (1954), "In the last analysis, there is only one psychotherapy, with many techniques" (Rockland, 1989, p. 542).

Of further relevance to training is the finding of this study that a considerable number of participants reported a lack of knowledge of ideal treatment of patients diagnosed with severe personality disorders. This finding suggests that specific attention in training to treatment of these patients may be warranted.

Two additional findings which have relevance to training with respect to this patient population bear mention. One participant said that patients with personality disorders were generally considered to be those "you throw out the door". Some participants, however, expressed positive views and feelings specifically with regard to patients diagnosed with the borderline personality disorder. As was noted earlier, it might be hypothesised that these positive orientations were a result of increased confidence in treating this particular

¹¹ This observation is based on personal experience.

patient group (due to recent, extensive literature coverage). Based both on this hypothesis, and the report of generally negative views regarding patients diagnosed with severe personality disorders, it would seem that psychotherapy training might usefully include the treatment of patients diagnosed with a variety of personality disorders, including those which to date appear to have received relatively little literature coverage (e.g. dependent or passive aggressive personality disorders). Increased confidence, and consequently more positive views regarding the treatment of a wider spectrum of patients diagnosed with severe personality disorders, might thereby be achieved.

Regarding the reported problems of internal referrals, discarding of the terms ST and SP may be helpful in resolving some of the difficulties. Instead of receiving referrals for ST / SP which might only convey that the therapist "is not expected to work miracles and ... [that the patient] is not suitable for psychoanalysis" (Schlesinger, 1969, p. 275)), psychologists might usefully request that referral agents furnish certain details of apparent treatment requirements. This request may facilitate assessment and articulation of patients' needs by the referral agents (indication of individual needs were described as lacking), and may thus permit therapists to plan services more systematically. Increased efficiency and efficacy of services as well as improved patient and therapist satisfaction might thereby be achieved.

An appropriate referral form might be designed to facilitate provision of relevant information by referral agents, as well as to indicate what treatment options are available (information which, as it was noted earlier, may not have been known to referral agents).

At the outset of this study referral forms were not used, but during the course of the study a form was devised by hospital psychologists. This form provided the opportunity for referral agents to choose from several treatment options, including "long-term psychotherapy", "brief-term psychotherapy" and "supportive counselling". Given the potential problems (discussed above) regarding use of such terms as discrete categories, it would appear appropriate to revise this form. (Furthermore, introduction of a term not generally used in the literature, "supportive counselling" - particularly without any explanation - creates the potential for additional confusion.)

Based on the literature and findings of this study which describe treatment objectives and strategies of both "insight-oriented" and "supportive" psychotherapies, and on this study's findings regarding referral problems,

it would seem appropriate that a referral form for psychotherapy include questions regarding the following details:

- the primary treatment goals considered appropriate (e.g. resolution of early conflicts or traumas / resolution of current interpersonal conflicts / promotion of psychological stability / improvement of behavioural functioning).
- the expected initial requirement regarding frequency of sessions (e.g. twice-weekly / weekly / monthly / more frequently / less frequently).
- the expected requirement regarding duration of treatment (e.g. weeks / months / years).
- the format of psychotherapy considered desirable (individual / group / marital / family).

Such a form would need to convey that final decisions about treatment would depend on the psychologist's assessment.

A number of issues pertaining to psychotherapists currently working at Greenwood Hospital, and to psychotherapy teachers, warrant further consideration. One issue is the finding of this study that ST / SP was said to have limited status amongst clinicians. Secondly, psychologists - said to be the only participants who received referrals for ST / SP - formed the one group most commonly identified as being negatively disposed towards ST / SP. Thirdly, ST / SP was reported to be a preferred psychotherapy by only a small minority of participants - excluding psychologists. Fourthly, most of those who gave reasons for feeling positively about performing ST / SP, said that this form of treatment was "useful". Descriptions such as "thrilling" and "exciting", used to describe insight-oriented therapy, were notably lacking. The fifth concern relates to the knowledge and expertise of teachers with regard to psychotherapy which departs from the traditional, insight-oriented model. Given that some teachers might themselves have had limited training with regard to such psychotherapy, there might be those who feel and / or are ill-equipped to provide the necessary training.

It would seem that these five possible problems of immediate relevance might be addressed through study and / or peer supervision groups attended by hospital, academic, and possibly other psychotherapists (such as those in private practice). Rather than being viewed in terms of SP, such groups might have as their focus the treatment of patients not suited to traditional techniques, and might focus on marrying theory and practice. A documented research component of such a group could offer an important contribution towards developing the theory and practice of psychotherapy. Furthermore, through sharing and developing ideas

and experiences, psychotherapy commonly considered "dull" and uninviting, though useful, might in time be viewed with the fascination presently associated with the traditional model.

Before concluding this dissertation, it is important to consider the possible ramifications of the approaches suggested above. Although the possible changes appear straight-forward in abstract, their implementation may be problematic. For example, taking a decision to stop using a term - the existence of which itself indicates that it has certain functions - would necessarily result in various degrees and forms of tension or discomfort. It would seem important that, before and during consideration of any of the above changes, the possible difficulties or obstacles be addressed. In addition to avoiding unnecessary problems, attention to these difficulties might in itself raise important issues, the consideration of which might contribute towards the development of psychotherapy.

CHAPTER 4: CONCLUSION AND RECOMMENDATIONS

Despite the fact that results of this study are not necessarily generalizable to all clinical staff of the hospital, or indeed farther afield, and that the analysis was limited by practical constraints, findings of the study bear consideration by hospital staff, training institutions and other interested psychotherapists. Many of the issues raised by this study are supported by literature and / or have implications for the development, practice, and training of what is commonly called ST / SP.

Based on these issues it is recommended that certain avenues be considered. In sum, discarding of the terms ST and SP (as suggested by Frank, 1986) could be considered, and less traditional psychotherapeutic models could be developed and described in terms of existing "formal" theories and psychotherapies (such as "psychodynamic" or "cognitive"). At the same time, clarity could be gained in a number of ways, including the following: (1) conceptualizing psychodynamically oriented psychotherapy as consisting of both supportive and exploratory modalities, and when applicable, describing such therapy in terms of "primarily supportive" or "primarily exploratory (or insight-oriented)" modalities, (2) using the various terms provided by the literature and / or the participants, for interventions based on other theories and / or models (e.g. case management, counselling, crisis intervention, pharmacotherapy, psychoeducation, psychosocial rehabilitation, and skills training), (3) using the term support to refer to interventions not necessarily based on recognised theories or models, and (4) using the term psychotherapy when intending to convey that an intervention is structured and informed by psychological theory.

Comprehensive training of psychotherapists in assessment and treatment, an appropriately detailed referral form for psychotherapy, and study and / or peer supervision groups might be considered as possible means of developing and improving the practices, views, feelings, status, and theories with regard to psychotherapy which departs from the traditional, insight-oriented model.

Attempting the above changes will be met with difficulties. These difficulties may, however, in themselves be useful. Their consideration may stimulate further thought and debate about important issues, and thereby contribute towards the development of psychotherapeutic modalities which have relevance to the majority of patients of Greenwood Hospital - if not to most patients of state-subsidised, psychiatric hospitals in South Africa.

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APPENDIX

INTERVIEW SCHEDULE

Preamble

per telephone:

I am conducting research which will be used towards completion of my master's thesis. It involves investigating people's views and feelings about certain aspects of therapy. I wondered whether you would be willing to be interviewed.

to the interview:

Thank you for agreeing to be interviewed.

I would like you to know that your **personal identity will remain confidential** with respect to any form of reporting arising out of the study, including discussions I might have with people.

I am interested in hearing people's **personal views and feelings** related to therapy.

I hope to use the results of the study to help clarify the **terminology and use of therapy** in the hospital. Ultimately I would like to **make recommendations concerning the application of therapy**, for the hospital and for other teaching institutions.

I would like to **audio-tape** our discussion so that I don't have to interrupt it by taking notes. Are you agreeable to this?

Questions

KEY: ST = supportive therapy
SP = supportive psychotherapy

1. For how long have you been working at Greenwood Hospital?

2. Through which institution did you / are you doing your O.T. / psychiatric / psychology / social work training?
└> When did you / do you hope to complete your training?

3. Did you study in any other field before you studied O.T. / psychiatry / psychology / social work? (If appropriate, ask which field(s)).

4. Have you worked in any institution besides Greenwood Hospital? (If appropriate, ask which institutions).
└> Were you ever in private practice?

5. In which wards or areas of Greenwood Hospital have you worked?

6. I am interested in your opinions about treatment of certain types of patients.
└> Would you please tell me what you believe to be the ideal treatment for patients who, in the old terminology, would have been diagnosed as suffering from neuroses (or in the current terminology, from conditions such as anxiety disorders or somatoform disorders).
└> And what do you think is the ideal treatment for patients who have recurring psychotic conditions?
└> And your view of the ideal treatment for patients with severe personality disorders?

7. Do you think that Greenwood Hospital provides adequate services and therapy for its patients?
└> Would you elaborate please?
└> If "no": What do you think are the reasons for this?

8. What are your thoughts or feelings about the relapse rate at Greenwood Hospital?

9. I am interested in your use of certain terminology.
- ↳ Do you use either of the terms ST or SP?
 - ↳ If "yes": Which do you use?
 - ↳ If "no": Do you have a deliberate reason for not using the terms? (If appropriate, ask for details).
10. Do you understand the terms ST and SP to have the same meaning?
- ↳ If "no": What do you understand to be the difference or differences between them?
11. How clear do you think you are with respect to what ST / SP is?
- ↳ How does this compare with your clarity with respect to what insight-oriented psychodynamic therapy is?
12. What do you understand by the term(s) ST and / or SP?
- ↳ Ask the following questions if not already answered:
 - What would you say is the length of sessions of ST / SP?
 - What do you understand to be the frequency of sessions of ST / SP?
 - Over what period of time would you expect ST / SP to extend?
 - What do you think are the aims of the therapist performing this / these form(s) of therapy?
 - What do you understand to be the theory(ies), if any, underlying ST / SP?
 - What do you think are the activities, strategies or techniques of the therapist performing this / these kind(s) of therapy(ies)?
 - If potential benefits of this therapy are implied:
With what type of patient or condition do you think ST / SP may be helpful?
 - In your view, is ST or SP the same as counselling?
 - ↳ If "no": How do you think they differ?
 - Do you think that ST or SP involves uncovering of unconscious material?
13. In comparison with insight-oriented psychodynamic therapy, how much skill do you think is required in performing ST / SP?
14. Do you receive referrals for ST / SP?
- ↳ If "yes": From whom do you receive such referrals?
 - ↳ Do you think these referrals are mostly appropriate?
 - ↳ In what way would you say they are appropriate / inappropriate?

15. Have you performed any ST / SP at Greenwood Hospital?
- > If "yes": How much of your clinical time would you say you spend / have spent doing ST / SP?
 - > If "yes": Would you give me an example of a patient you have treated with ST / SP, and tell me about the therapy you performed?
 - > Would you say that in your experience this is an example of a fairly typical ST / SP case?
 - > If "no": How would you say it differs from the usual ST / SP you perform?
 - > If "yes": How do you feel about performing ST / SP?
 - > If "yes": Do you currently perform ST / SP?
 - > If "no": Why is this so?
 - > If "no": Is there a particular reason why this is so?
 - > If personal choice not given as a reason: Would you have liked to have done this type of therapy? / Would you like to perform it at present?
 - > If "no": Could I ask why not?
 - > If personal choice given as a reason: Would you elaborate please?
16. What type or types of therapy do you prefer to perform?
- > What is it about this / these therapy(ies) which you find relatively attractive?
17. What type(s) of therapy do you prefer not to perform?
- > What is it about this / these therapy(ies) which you find less attractive?
18. How confident do / would you feel performing ST / SP?
[If participant refers only to pharmacological therapy, ask about therapy of a psychological type].
- > How does / would this compare with your level of confidence in performing insight-oriented psychodynamic therapy?
 - > For psychiatrists and registrars: And how does / would it compare with your confidence in performing pharmacological therapy?
19. Turning to assessment of patients for therapy:
- > Do you, as a matter of course, assess patients' suitability for insight-oriented psychodynamic therapy?
 - > And do you, as a matter of course, assess patients' suitability for ST / SP?

20. What factors do you think indicate that a patient is suitable for ST / SP?
- ↳ Do you think that there are any factors which indicate that a patient is **unsuitable** for ST / SP?
21. How confident do / would you feel in assessing patients' suitability for ST / SP?
- ↳ How does / would this compare with your level of confidence in assessing patients' suitability for **insight-oriented psychodynamic therapy**?
 - ↳ And with your confidence in assessing patients' suitability for **pharmacological therapy**?
22. Did your psychological or psychiatric training include ST / SP?
- ↳ If "yes": What form did this training take? [*Prompt if necessary*: for example, seminars, supervision, lectures and so forth].
 - ↳ What is your assessment of your training in this / these form(s) of therapy?
 - ↳ If negative: What recommendations would you make to improve the course in ST / SP?
 - ↳ If "no": Do you think your training should have included it?
 - ↳ If "yes": What form do you think such training should have taken? [*Prompt if necessary*: for example, seminars, supervision, lectures and so forth].
 - ↳ How much emphasis do you think ST / SP should have been given in your course?
 - ↳ If "no": Would you explain your answer?
23. Do you think that ST / SP should fall within the scope of your discipline?
- ↳ If "yes": Do you think it / they should also fall within the scope of other disciplines? (If appropriate, ask which ones).
 - ↳ If "no": Under which disciplines, if any, do you think it / they should fall?
24. How much status do you think ST / SP generally has at the hospital?
- ↳ How do you think the status of ST / SP compares with the status of **insight-oriented psychodynamic therapy** at the hospital?
 - ↳ Do you think that the various disciplines in the hospital hold similar or different views about the status of ST / SP? [If different: Please elaborate].
25. I would like to look at feelings people have about working with patients who have severe psychiatric disorders which tend to relapse.
- ↳ How do you feel about working with such patients?
 - ↳ How do you think others in your discipline feel about working with such patients?

26. How do you think such patients generally relate in therapy?
- ↳ Do you think they tend to be more emotionally dependent on their therapists than other patients?
 - ↳ How does it make you feel when patients are emotionally dependent on you?
27. Turning to referring of patients outside the hospital, do you ever refer patients to (Welfare Organization) after discharge?
- ↳ If "yes": How frequently do you refer patients to them?
 - ↳ What type of patient do you generally refer to them, and for what form of intervention?
 - ↳ Do you have any reservations about referring to them?
 - ↳ If "no": Do you think it would be appropriate to refer, to (Welfare Organization), Greenwood Hospital patients requiring psychological intervention after discharge?
 - ↳ If "yes": For what type of patient and for what form of intervention?
 - ↳ Would you have any reservations in referring to them?
 - ↳ If "no": Why not?
28. If reference has been made to inadequate services or therapy: I have one last question related to Greenwood Hospital. You expressed a view that some services / therapy / are / is lacking at the hospital.
- ↳ Do you have any ideas of what could be done to improve the situation?
 - ↳ Have you made any attempts to improve the situation?
 - ↳ If "no": May I ask what might have stopped you from attempting to change the situation?
29. Would you like to make any further comments or any suggestions?
30. If I have forgotten to ask you anything, may I contact you again?