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Too Close for Comfort: Emotional Ties Between Nurses and Patients

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It is not enough that community psychology focuses only on specialist mental health services in community settings. It is imperative that we use our skills to contribute to understanding and working with the emotional processes involved in the broader social arena. In a country undergoing major transformation there is a particular need to attend to some of the psychological demands this places on its citizens. To date, change management in many institutions has focused on structural changes such as salary scales, integration of services and formation of new management structures. This paper raises the need to take into account the emotional issues that play a significant part in blocking changes at the level of individual and interpersonal adjustment.

In this chapter I highlight some of the emotional issues that occur in everyday work settings between nurses and patients in public health services. In the 1950s, Menzies Lyth (1960) described the defences used by nurses in hospitals in Britain. Using psychoanalytic theory, she argued that many of the institutional routines of the hospital served the function of protecting nurses from their difficult experiences of patient care – including the demands of working with people who are very ill and even dying. This classic description of the ways in which nurses and service organisations as a whole defend themselves against the anxieties associated with their work has important lessons for the contemporary South African public health system (van der Walt & Swartz, 1999). Health authorities in South Africa are faced by enormous challenges including limited resources, high demand on their

services and high levels of poverty amongst their patients. In this paper I explore the kinds of anxieties faced by nurses working in several tuberculosis (TB) clinics and the effects of their interaction with their patients.

It is important to note that these observations were made during the early years of political transition in South Africa. I hope to illustrate the subtle yet powerful ways in which issues of race, colour and self-identification influence the relationships between nurses and patients. The backdrop to the case study I present here is the Tuberculosis Control Programme in the Western Cape Province.

Tuberculosis in South Africa

Apart from HIV/Aids, TB is the single biggest public health problem in South Africa and one which carries significant social stigma for those who are infected. The notification rate of 578 per 100 000 in the Western Cape is the highest in the world (Department of National Health and Population Development, 1996). The TB Control Programme takes up most of the nursing staff's time in local authority clinics (Dick & Pekeur, 1995). The best modern drugs are freely available, yet the cure rate is not satisfactory, with high levels of drop-out and non-compliance (Dick, Groenewald, van der Walt & Rose, 1996). Up to two-thirds of patients leave the programme before the end of treatment. They run the risk of becoming re-infected, and could remain a source of infection to others, or even worse, contribute to the spread of the new strain of TB which is resistant to most anti-TB antibiotics and therefore incurable. This has serious consequences for the efficacy of treatment and curbing the spread of this disease. Although TB patients in this system receive a minimum of six months' care, this has been based on a routinised, mechanical, biomedical model which largely ignores the illness experience of patients. The morale of staff working in the programme is often low. Nurses feel overburdened and frustrated when patients fail to adhere to the full treatment regime.

Addressing the problem

It was in this context that a provincial TB co-ordinating committee agreed to pilot an in-service training programme for the staff of two local-authority health centres. The purpose of the course was to update staff with the latest knowledge on the TB epidemic, to encourage them to critically examine their own practice and to stimulate them to change their work patterns. Each clinic was ordered by top management to send a group of nurses to attend the course.

I shall refer to the two centres as Deepvalley and Vista. Deepvalley is a typically segregated coloured township which was built in the early 1970s during the height of the apartheid era. The health centre is overcrowded and on busy days the queues spill out onto the veranda. All the nurses at the centre are coloured women who live elsewhere and commute to Deepvalley. Vista is a run-down industrial neighbourhood on the edge of the inner city. It is equally crowded. The patients are mainly coloured and black with a small sprinkling of whites. The nursing staff is more of an ethnic mix: roughly half of the nurses are coloured

and the other half white. The course organisers were taken by surprise when the entire Vista delegation to the course turned out to be white nurses. When asked about this, they said that their coloured colleagues were not available to attend the course at the time.

The training team was headed by health systems researchers of a government medical research unit and by senior managers from the health authorities. My particular task was to do a qualitative evaluation of the outcome of the course. This included an assessment of staff morale before and after the programme. I was also required to monitor self-initiated changes following the training.

Prior to the course, both groups were reasonably pleased with their performance. Vista said their clinic ran 'like a well-oiled machine'. Deepvalley felt that they were doing well 'under the circumstances'. They said, however, that they were frustrated by the poor motivation of patients to take responsibility to complete treatment and seemed to convey a feeling of futility and hopelessness about their work.

The course itself was based on adult education principles and experiential learning. For instance, staff were asked to map the flow of patients through their clinic and to study the amount of time patients spent waiting for, and being attended to, by staff. In another exercise, they visualised their ideal clinic and were then asked to analyse the potential barriers to implementing their ideal. At the end of the course the participants planned the changes that they wished to initiate.

During the course the Vista nurses appeared to make some dramatic discoveries. They found that patients were spending too much time waiting in different queues and that there was no continuity in care. They planned a complete overhaul of the work routine which would allow more time for patients to be attended to individually. Despite considerable resistance from their doctor and nursing colleagues, they forged on and managed to persuade even top management to make some fundamental changes that facilitated the implementation of their new ideas.

Deepvalley, on the other hand, made no startling discoveries about their practice. They seemed to accept the 'conveyor-belt' orientation to their work as a reality that could not be changed. They, however, took pride in mastering the new administrative system for registration of TB patients. Their other idea for change consisted of a plan to improve patient support, but this was to be organised as an additional task that had to be added onto the exiting service routine. The nurses planned to encourage patients to run self-help groups. This would mean that patients had to come to the centre for an extra visit to attend the support group. In monitoring the effectiveness of this change later, we were not surprised that patients who already came in every weekday were reluctant to participate in such a scheme.

Discussion

The two groups had attended the same course; they both did similar work and yet their responses to the course could not have been more different. While both groups recognised the

need for patients to receive support in order to help them adhere to treatment, they had different ideas on how to address this need. Trying to make sense of this difference gave me the rare opportunity to uncover some of the deeper emotional dynamics which inform such responses.

A safe distance?

What was immediately evident to me was that the two groups spoke about patients in very different ways. There were individual differences in each group, but on the whole it seemed as if the group of white nurses were less angry and judgemental about their patients than were their coloured counterparts. In trying to makes sense of this unexpected phenomenon, I began to think that it might have something to do with the white nurses' sense of distance from the personal reality and racial identity of their coloured patients. It appeared that when patients were seen by their nurses as different in terms of class, race, income and educational background, closer contact was less threatening. This distance seemed to enable the white nurses to tolerate and make allowances for the behaviour of their coloured patients in a way that coloured nurses could not. White nurses perhaps did not have to fear 'contamination' by their patients when they allowed social contact or presented themselves as being more human. They seemed instead to be able to allow feelings of charity and compassion to guide their behaviour. It is possible, of course, that with the legacies of apartheid these feelings of white nurses for their coloured patients may have been strengthened by guilt. The similarities between coloured nurses and their patients may, on the other hand, have led to fears about losing their identity which hampered their capacity to relate warmly and empathically in their work.

Too close for comfort?

The Deepvalley nurses seemed embarrassed by what they saw as the 'deviant behaviour' of their patients. Some of these nurses, it appeared, grew up in similar areas and under similar social conditions of poverty and deprivation. Members of their families and some of their neighbours may in fact have had TB. Nursing was, at the time, one of the few career options that offered young coloured women the opportunity for professional qualification. A nursing qualification, often obtained with great determination and sacrifice, represented an 'upliftment' out of the situation of the average patient with TB. The nurses, it seemed, now expected a similar capacity to better themselves in their patients. Ironically, this close identification frequently manifested in a top-down relationship in which the nurses would set themselves up as critical authority figures in relation to their patients. In speaking of their patients the implicit message appeared to be: 'We know "our people"'. They presented themselves as knowing what was best for the patients and retaining their right to 'scold' on the basis that they cared for and wanted to help them. In turn they expected the patients to take responsibility for their own treatment. Some of these nurses spoke with great anger and frustration about patients who failed to comply with the treatment regimen. In order to enforce compliance, they were keen to increase their control over their patients. This was

clearly illustrated when a nurse suggested that Robben Island[1] should be used as a prison colony for non-compliant patients.

In general many TB clinics operate on a task-centred system which is designed to keep patients moving through a series of stations where a nurse fulfils a single task, for instance history taking, weighing or collection of sputum specimens. There is little opportunity for the patient to actually get to know any individual nurse. Although apparently designed with efficiency in mind, this system functions to prevent closer emotional contact between nurses and patients. At Deepvalley, although the nurses were aware of the need for patient support, they saw this as just one more task to be added to the existing range of one-stop stations, where it could be offered by the patients themselves or by one of the health educators.

This compartmentalised system, which seems to offer a degree of emotional protection to the nurses in their dealings with patients, takes on further meaning in the South African context. It is important to remember that, under the apartheid government, it was official policy to ensure that each 'population group' be given healthcare by its own members. As early as 1952, Cape hospitals started a scheme for the training of 'non-European nurses to take care of their own people' (Marks, 1994, p.171). Marks shows how the early missionary-based training schools influenced nurse trainees to 'wage war against the ignorance, disease and superstition of their people' (1994, p.109). This, together with the drive for professionalism and higher status for nurses, understandably widens the distance between nurses and their TB patients.

One of the most typical features of service delivery in the local-authority clinics I visited was the very impersonal way in which nurses appeared to interact with their patients. Menzies Lyth (1991, p.361–364) describes how British nurses who worked in stressful situations developed coping mechanisms to deal with their anxiety. One of the mechanisms she describes is the way in which nurses seem to deny the significance of the individual (patient or nurse) through rituals which emphasise uniformity and therefore diminish the risk of too close personal contact. This behaviour is common to clinics (van der Walt, 1995), regardless of the colour of staff, but it is interesting that the coloured staff of Deepvalley chose to maintain their distance from patients, while the white Vista group were prepared to consider changing their routine in order to make closer contact with patients.

Talking about colour

It took some time for me to acknowledge these observations, even to myself. At the start I expressed them very tentatively, largely because of the fear of being, or being seen as, racist. During the years of resistance against apartheid, progressive academics drew on critical theory to support a discourse emphasising similarities between cultures in order to counter the government's focus on differences between ethnic groups (Kottler, 1996). To talk or write about differences came to be seen as support for apartheid and as being racist. In the initial attempts to find an identity for the 'new' South Africa there was great support for

1 The infamous offshore prison in which Nelson Mandela and many other anti-apartheid activists were imprisoned for long periods of time.

non-racism in the context of an overarching concern for 'nation-building' which emphasised commonality between different groups (Swartz, 1996).

I do not believe that all coloured nurses deliberately avoid closeness with their coloured patients, nor that all white nurses are willing to experiment with getting closer to patients of a different racial group. I suspect rather that this is a complex phenomenon and one which happens at an unconscious level. My sense was that closeness was also tied to the extent to which nursing staff identify themselves as being 'insiders' or 'outsiders' in relation to the community of patients. This was well illustrated by the behaviour of a black nurse who worked at Vista, who felt like an 'outsider' because she was from elsewhere in the country. She established remarkably warm and close relationships with both coloured and black patients. It seemed to me that her experience of being an 'outsider', and the absence of a strong identification with her patients, or colleagues, enabled her to establish more human relationships in the course of her work.

While I was thinking about these kinds of issues, I had a vivid memory of a time when I was employed as a nurse in a community-based primary healthcare service. After working in areas designated as coloured, I was transferred to another area to do relief duties. I was shocked at what I found there: white people, mainly Afrikaans-speaking like myself, who lived in sub-economic housing. Many of the patients were unemployed and there were high rates of many of the difficulties associated with poverty, including alcoholism and malnutrition. I remember thinking angrily that since these people were privileged because of their colour, they had no excuse to be like this. I felt ashamed of them and embarrassed by them. I never had these feelings about coloured and black patients. Thinking back, I recognise how my insider status of being close to the white patients could have triggered my discomfort.

Given our histories under apartheid, it is perhaps hardly surprising that race and identity seem to play such an important role in our working lives. The deliberate implementation of segregated neighbourhoods, schooling, professional training and health services in South Africa has strengthened and emphasised these feelings of identity with people of our own colour. I suspect that in a more open society people's feelings of being 'too close for comfort' would be less overwhelming. In South Africa we have a long way to go before we reach that stage. The legacy of apartheid lives on in most public health services such as Deepvalley, where deeply internalised racial politics play themselves out in unexpected ways.

Colour and course dynamics

It is not only between nurses and their patients that the dynamics of race play themselves out. The course itself helped to reveal the ways in which racial identity became a fundamental part of the way that colleagues within the nursing system interact with one another. Coloured people under apartheid were constructed as second-rate citizens and provided with limited opportunities to exercise their own choices in life. Coloured nurses were forced by state authorities to attend segregated schools and nursing colleges, and to work in health services situated in coloured areas. For the coloured nurses who were

instructed to attend our particular TB training course it might have felt like yet another example of being 'sent off' somewhere by those in authority. Their *en masse* attendance on the course may say less about their enthusiasm for its subject matter and more about compliance and a feeling of safety in numbers. At the first session of the course, the coloured nurses from Deepvalley would have found that the entire training team was white. Unwittingly, the fact that those in authority were white reflected the power dynamics of the apartheid era.

Not only were the staff team white, but the whole group from the Vista clinic were also white. These two factors in combination seemed to place the group of coloured nurses in a potentially threatening position. When evaluating the course, both groups said it was a good experience to meet the other group and it made them realise that theirs was not the only clinic that was having problems. However, the Deepvalley group seemed to have a particular investment in presenting their clinic as running more smoothly than that of the Vista group. This representation of their clinic's functioning would have helped them to manage any feelings of uncertainty about their position on the course and perhaps reflected their anxieties about opening up their own practices to potentially unsympathetic scrutiny. This would have been particularly painful given the disparity in the circumstances of the two groups. Furthermore, it is likely that the energetic strategising and initial successes of the Vista group in identifying areas in which they wanted to make changes would, ironically, have highlighted Deepvalley's own feelings of impotence to make changes.

Group processes

The work of Bion on psychological processes in small groups (Stokes, 1994) may shed some light on the behaviour of the two groups during the training course. In this view, group behaviour is directed at trying to meet the unconscious needs of its members. Bion recognises that while groups may appear to be attending to the rational demands of their 'primary task', there is also a powerful unconscious tendency in groups to respond irrationally in an attempt to avoid painful areas of conflict.

In helping institutions staff often lack adequate task definitions and receive little guidance from managers on their effectiveness (Strachan, 1995). Lawrence (cited in Zagier Roberts, 1994) suggests that organisational behaviour can be studied by examining the way in which employees pursue different kinds of primary tasks within an organisation. He distinguishes between the normative primary task which is the official task defined by the senior managers; the existential primary task which is the task that the staff believe they are doing; and lastly, the phenomenal primary task which can be inferred from people's behaviour, and of which they may not be aware. When a group does not know its primary task, it tends to invent another task. This is usually the case in basic assumption groups who display anti-task behaviour to meet the psychological needs of the group members. The sophisticated work group, on the other hand, gets on with the primary task which relates to the demands of the external environment.

The Vista team operated as an open group whose purpose was to improve the cure rate of

patients by re-arranging their clinic routine in order to provide maximum contact time between patients and nurses. In order to achieve this, they operated like a task-focused working group. Back at their clinic they had to convince colleagues of their vision and to obtain their participation. Deepvalley, on the other hand, closed their ranks and turned inward like a closed group that exists solely for the protection of its members. This was already clear in their decision all to attend the course. Their leader collaborated in this process by protecting them against painful changes. This became evident in the way they held on to their existing clinic routines (their existential primary task) which contained their anxiety, rather than the patients' need for support.

Another feature of group behaviour is its relationship towards authority. Vista staff acted with authority when they presented their plans to the management. The staff at Deepvalley described themselves as 'adaptable' to any changes proposed by head office. Yet there was an underlying anger about not being consulted: 'Everything is already planned and sometimes we feel... look we know a lot about the problems on the ground... why don't they discuss things with us and ask our views?' These rumbles remained in the group. In the basic assumption dependency mentality groups assume that authority is based entirely in the hierarchy which calls for unquestioning behaviour.

Why the complete acceptance of the register and the pride that they are the only clinic staff who understand the rationale for it? Obholzer (1994) describes the defensive structures in public-sector organisations. He uses the concept of containment to describe how employees make their anxieties more bearable or contained. Defences against the painful realities of the work are managed by arranging the work into certain tasks, rules and procedures ('Yes, the patients need more support, but limit it to Thursday afternoons from 2 to 3p.m.'). Only if there is an agreement on the primary task of the organisation and a willingness to be in touch with the anxieties inside the container rather than blocking them out, is it possible to deal with or contain anxieties. For this to happen it is necessary to have opportunities for dialogue within the organisation. Unfortunately our public health services do not function like this – managers are kept at a distance from patients. The 'caring' component is removed from management and clinical staff have to protect themselves from the realities of pain and illness. This is done through learning to turn a blind eye to the realities and to organise work in such a way that anxieties are pushed back. This could stand in the way of doing the primary task, which in this case is to support patients in adhering to the lengthy treatment of a stigmatised, infectious disease. The emphasis on administrative work could be part of this process. If we fail to recognise the anxiety-containing function of an organisation, changes can create more problems because they lead to the dismantling of structures which were created to defend us against anxiety. In the case of Deepvalley, a change from a task orientation which served to contain anxieties by providing distance between patients and nurses, to a more patient-centred approach, could lead to staff burnout and illness.

Implications for health systems reform

Human beings are resistant to change and therefore managing change will require managing the anxieties and resistance which will arise from the change process. The more well-known sources of organisational resistance are a threat to established power relations, threat to established resource allocation, threat to expertise, the limited focus of change, structural inertia and, lastly, group inertia (Robbins, 1993, p.637). The case of Deepvalley has illustrated a form of group inertia and has provided the opportunity to dig beyond that label in order to unearth some of the deeper-lying anxieties.

What can be done to facilitate change processes? Obholzer (1994), suggests a few pointers. It is important to be clear that any proposed changes will serve the primary task of the organisation. Staff and management need to have similar views of what the primary task is. Group consultation with outside consultants may be necessary to raise the awareness of situations when groups change from working groups to basic assumption groups.

Work-related staff support should be legitimised in order to contain the anxieties of the work and those related to change. This would enable staff to discuss feelings and problems in a climate that regards problems as a normal aspect of the work, rather than as evidence of personal or group pathology. This will require a major change in the public health system where nurses and other groups of caregivers have systematically been socialised to suppress their feelings. The use of external consultants could facilitate the process and protect the space from being eroded by work pressures or group defences.

In-service training programmes need to be planned with the utmost care. Important guidelines would be to meet participants before the onset of the course in order to assess their needs and their perceptions of the course. The group composition in terms of colour and gender needs to be considered carefully and where such stark divisions are inevitable, as may well be the case during the transition period in South Africa, needs to be opened up for discussion. It will require much courage and sensitivity to break through the taboo of talking about colour and to uncover the underlying experiences which inform our behaviour. Similarly, the anxieties and fears of change should be addressed as part of the agenda of the course. And, lastly, the facilitators should show equal respect for those groups and individuals who choose not to adopt any changes.

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