“Thinking Too Much”: A Clash of Legitimate Values in Clinical Practice Calls for an Indaba Guided by African Values-Based Practice

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21.1 Introduction

The practical concern of this chapter is with legitimate values that are clashing in clinical practice. The chapter illustrates an accountable way of dealing with such clashes as guided by an African version of values-based practice (A-VBP), [1, 2] which averts default responses to these clashes that tend to be destructive and failing both the clinician and the patient. For example, when values clash between a clinician and a patient, A-VBP averts the professionally eroding response by which to do “whatever the patient wants,” sometimes advocated in the name of anti-paternalism or respecting personal autonomy [3]. A-VBP averts on the other hand the domination of the clinician’s values in, for example “I offer only what is medically best—take it or leave it” [1].

The role of A-VBP in clinical care is illustrated here by the story of Akanya.¹ This concerns two major decision points in his clinical management: when he presented to health services with an acute psychotic episode for the first time and 8 years later when he wanted to discontinue his antipsychotic medication.

21.2 Akanya’s Background

Akanya’s grew up as a lonely and unusual child in a rural community in South Africa. Whilst his father and most of the community in which he lived were Setswana speaking, his mother’s mother tongue was isiZulu and she was considered to be, like

¹ Akanya is a pseudonym meaning “to think” in Setswana.

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her only child, an outsider. His mother had a rather critical perspective on most people and their actions. She took pride in her neat organised way of doing her daily chores. His father was often alcohol intoxicated, usually over weekends. Both his father and mother lived in a rural community all their lives, were illiterate and made a living through communal subsistence farming.

In contrast with his illiterate parents, Akanya was an avid reader. His favourite books were science fiction, popular psychology and books that espoused Buddhism. His parents and most of his community hardly knew anything about these topics and they considered his conversations as strange. Attempts at befriending him never lasted. His teachers were similarly puzzled, even more so because his marks were inconsistent and incongruent with the extent of his knowledge of and insights into some topics. They thought he underachieved in obtaining merely average marks in spite of various indications that he was actually exceptionally bright. The teachers and community attributed all these oddities to “thinking too much”, which they thought was foreboding much trouble to come.

21.3 The First Major Decision Point

The troubles they had anticipated, culminated when Akanya was 19 years of age and in their view, his “thinking too much” got out of hand. A general medical practitioner identified various persecutory delusions, by which he was accusing his parents that they wanted to deliver him to Satan and they had been colluding with the community leaders to have him put away. He also had delusions of thought insertion by which his ancestors were putting thoughts into his head—thoughts that were not his and had been taking over control of his life. During the preceding week, he had been verbally abusive towards his parents, and threatened to kill them and the leaders of his community. He also expressed ideas of killing himself rather than giving them the “joy” of doing so.

The practical and ethical difficulty at this time was about invoking the Mental Health Care Act (MHCA) and admitting him to hospital on an involuntary basis. His parents were reluctant that he be taken away to a psychiatric hospital. One of their reasons was that they did not want to do precisely what their son had been accusing them that they would be doing, i.e., colluding to have him incarcerated. His parents had no appreciation of his behaviour being part of a psychiatric disorder and insisted on taking him to a traditional healer instead.

These demands posed several difficulties for the general medical practitioner, Dr Robertson, who was called to see Akanya for the first time. It seemed clear to him that Akanya was suffering a psychotic episode and needed hospitalisation even though he was resisting this. But being of a different culture, Dr Robertson was concerned that by invoking the MHCA for involuntary treatment, he would be alienating the parents and even be accused of being dismissive of and perhaps violating the cultural beliefs and practices of Akanya’s parents. The MHCA also required that the parents complete an application form for involuntary treatment and that one resorts to another applicant only in exceptional circumstances. Weighing against

these considerations, Dr Robertson was acutely worried about Akanya's volatile mental state and high risks of harm to his parents, community leaders and himself. He remembered being taught as a medical student that homicidal and suicidal behaviours were rather unpredictable in situations like these. Finally, in addition to his concerns for all those involved, Dr Robertson was aware of his own professional and legal obligations to apply the MHCA in this situation.

21.4 Course of Events Before a Second Major Decision Point

After his period of involuntary hospitalisation, Akanya regularly attended as an outpatient at a public mental health facility and the need for a second hospitalisation did not arise. Whilst his acute psychotic symptoms abated on a standard dosage of anti-psychotic medication, his depressed state remained for about 6 years in spite of trials on various antidepressants. He considered his depressed mood as precious to him, saying "feeling depressed is all I have". Excessive feelings of guilt dominated his clinical presentation about failing to live up to his parents' expectations in everyday activities at home, hardly ever venturing outside the house, and not even trying to get a job.

He often had suicidal ideas and his psychiatrist, Dr Mahlangu, reckoned that it would not be surprising to receive a phone call with news of his suicide. Yet, he considered continuous hospitalisation as unsuitable and tried instead to contain the risk of suicide within a therapeutic relationship. Subsequently, Akanya's depressed mood gradually disappeared and his suicide risk decreased but only over a period of about 6 years.

21.5 A Second Major Decision Point

Eight years after the acute psychotic episode, the need for a second major decision arose. Akanya had been seeing Dr Mahlangu every 3 months for monitoring and supportive psychotherapy. A trusting relationship was well-established, which contrasted with Akanya's skepticism and distrust towards people in general. As had been the pattern since adolescence, Akanya resorted to keeping his own company, avoiding social contact as far as possible. He experienced the social world as too daunting, overwhelming, insincere and pretentious. Not being employed, he spent much of each day in his room, often reading and collecting pictures and other items that would aid his memory as he had been trying to counter continually losing precious ideas. He subscribed to an unusual and complex world view, which he valued proudly as unique and shared with no one in particular. For example, his view was that expressing one's thoughts brought them to life in a universe of thoughts. Within this universe, thoughts might influence each other, and some modified thoughts might come back to one, or find entry into the mind of someone else. This universe of thoughts was but one of an infinite number of parallel universes.

*Akanya now wanted to discontinue his use of antipsychotic medication. This was a difficult decision, particularly for Dr Mahlangu who was not keen to do so at all. He believed Akanya was at high risk of relapsing into an acute psychotic episode should antipsychotic medication be discontinued. He based this on his assessment of Akanya's history, his impaired current functioning, and professional literature. On the other hand, Akanya maintained the medication was a means of the psychiatric profession sustaining their hold on patients. Dr Mahlangu was concerned that he would be exposed and criticised professionally, even found negligent, if he did not continue prescribing an antipsychotic medication in this situation as would be professionally expected, based on best practice and evidence based guidance. Confounding the difficulty for the psychiatrist was that he assessed Akanya's unusual thoughts (as above) to be overvalued ideas but not delusions. He was aware, however, that his colleagues might consider these delusions for which an **increased** dosage of antipsychotic medication would be indicated. When the psychiatrist shared his concerns with Akanya, Akanya took them as evidence for his conclusion about a professional hold on patients.*

21.6 Values and Evaluations of the Stakeholders

There are many potential conflicts of values both within and between the stakeholders in this narrative: the parents, the general medical practitioner (Dr Robertson), the community, Akanya, the psychiatrist (Dr Mahlangu) and the wider society.

The **parents** ascribed to the cultural value of consulting a traditional healer. This value is common to both Tswana and Zulu cultures (his father's and mother's, respectively). Regarding personal values, Akanya's father valued drinking alcohol, whereas his mother valued proudly her neatly organised way of doing her daily chores. She also evaluated critically most people and their actions. Both parents valued negatively their son being taken away to hospital and both were concerned that he would construe their actions as confirming his accusations of collusion. Furthermore, the narrative suggests indirectly through Akanya's take on the expectations of his parents, that his parents held the values that Akanya should participate differently in everyday activities at home, should venture outside more often and should attempt to get a job.

The **general practitioner**, Dr Robertson, evaluated Akanya's clinical presentation as comprising delusions with considerable risk to others and himself. He was particularly concerned that the parents, the community leaders and Akanya should not be harmed or even killed. The general practitioner recognised as important the cultural values of the parents, particularly with his culture being different. He valued negatively the alienation that might result from this difference and that he might be regarded as dismissive of and even violating their cultural values. He also valued compliance with the values of his profession and society (see below) regarding professional and legal obligations. With these values being in part conflicting, he evaluated the situation as difficult and demanding ethically and practically.

The **community** attributed Akanya's situation to "thinking too much," underpinned by their values that his thinking was excessive. They considered "thinking too much" as foreboding trouble if it got "out of hand," implying that it should not have been allowed to do so. They evaluated Akanya as "strange," an "outsider," and incapable of having lasting friendships, implying values by which he should not have been so. His teachers valued his academic abilities as exceptionally bright. They also held the values that he should have achieved better than average, consistent with the extent of his knowledge and insights.

From early on, **Akanya** valued his reading as a precious activity, especially on topics of science fiction, popular psychology and Buddhism. In his acute psychotic episode, he valued negatively the intentions and actions of his parents and community leaders, as if these were to his extreme detriment (e.g. delivering him to Satan; colluding against him to put him away). He evaluated control of his life as being taken over by his ancestors putting thoughts into his head—thoughts that were intrusive, unwanted and not his. He also ascribed value to committing suicide or to others killing him as holding potential "joy."

After the psychotic episode, Akanya valued his depressed mood as precious. Also, his ideas were precious and for this reason, he had to counter "losing" them by collecting pictures and other items in aiding his memory. He ascribed values of failure and guilt to his not meeting the expectations of his parents about everyday activities at home, venturing outside often enough and trying to get a job.

Akanya valued that he was different and had a "unique" worldview about parallel universes of thoughts. This was in conflict with the values of his community by which he was considered "strange" and an "outsider." He evaluated the social world as being too daunting, overwhelming, insincere and pretentious. Like his mother, he evaluated others skeptically with distrust towards people in general. He valued in a similarly negative way the psychiatric profession as maintaining a hold on patients through medication.

The **psychiatrist**, Dr Mahlangu, valued highly a trusting relationship with Akanya, considering this an achievement given Akanya's tendency to distrust others. He also valued highly the need to prevent Akanya from relapsing and hence was concerned about discontinuing his antipsychotics. In this, he valued following best practice based on best evidence. He also valued meeting professional expectations and standards in the assessment and treatment of Akanya. He recognised that his evaluation of Akanya's thoughts as being overvalued ideas rather than delusions might be at odds with an evaluation by his colleagues and profession. He valued negatively being exposed, criticised or found negligent by going against professional norms and expectations. Compounding these concerns was a recognition that an actual relapse could be evaluated as proof of his failure to prevent it.

In addition to the community values highlighted above, **other societal values** may also be identified. The values by which Akanya was considered abusive and threatening were shared by the wider society beyond that of the local community. Societal values were also captured in the Mental Health Care Act, which included obligatory values that prescribe how Akanya must be managed. Furthermore, some

of the values of the general practitioner and the psychiatrist highlighted above were also shared by society generally.

21.7 An Indaba to Process the Conflicting Values at the First Major Decision Point

“Indaba” is a word from isiZulu, the meaning of which includes “meeting”, “matter” and “story.” It captures a process common in sub-Saharan Africa, described inclusively as a meeting to discuss a matter where individuals and communities have a voice in generating a common story to tell about a matter of concern [4–6]. An indaba is an African way of following the communication pointer of values-based practice, whereby communication is meant to be an end in itself rather than the mere means to an end [1].

At the first major decision point described above, an indaba was held among the parents and Dr Robertson preceding the application of the MHCA. Although it would have been ideal, Akanya did not participate in this indaba since his parents and Dr Robertson thought that he was too disruptive and threatening. The indaba generated a shared story framed and driven by the common value, namely, Akanya’s best interest. It crucially accounted for the differences and specifically the conflicting values in this story. By adopting an appositional (i.e. on the same side) rather than an oppositional attitude in the indaba, Dr Robertson skilfully led the process by locating the clash as being between legitimate values rather than between people. The values of the parents were deliberately included in the story-making together with his professional values as well as societal values. The key question that drove the indaba was *how may (the story of) their shared decision account for the differences between values without dismissing or changing anyone’s values?*

Dr Robertson ensured that the differing values were made explicit in the indaba by providing space for the stakeholders to explain and understand each other’s concerns and interests. The parents explained their need for a consultation with a traditional healer and their worry that their son would construe their agreement to hospitalisation as confirming his accusations of collusion. Dr Robertson took these concerns seriously and explicitly said that they need to make a plan by which to incorporate these in their joint decision. In turn, Dr Robertson explained the provisions of the MHCA as an expression of how seriously society viewed this situation involving the need to protect Akanya, the community leaders as well as the parents. He also explained his position by which he was legally and professionally compelled to proceed with involuntary admission procedures, but he did so in a way that these societal and professional values were placed next to, rather than displacing, the values of the parents. He explicitly shared his concern that his action to proceed with involuntary hospitalisation would alienate them or be interpreted as him being dismissive of or violating their cultural values.

The indaba accordingly afforded a joint decision by which the prescriptions of societal values encapsulated in the MHCA were followed, because all were law-abiding citizens who had to make decisions within the law. The parental values

nonetheless were also part of the decision. It was decided that they would not complete the application forms for involuntary admission but that a community leader would do so instead. This, they felt, absolved them factually from their son's accusation that they would have incarcerated him. A further decision was that consulting a traditional healer would be postponed, being made either in discussions with the treating team during hospitalisation or thereafter.

21.8 An Indaba to Process the Conflicting Values at the *Second* Major Decision Point

Whereas the values of Akanya had to be put on hold temporarily during the acute situation, they featured centrally in the indaba 8 years later at the second major decision point. Dr Mahlangu skilfully made space for them alongside his values, maintaining a being-on-the-same side attitude even though their respective values were clashing. He made it clear that he considered it therapeutically important to account for Akanya's reservations and interpretations about antipsychotic medication in their shared decision. They nonetheless also accounted for the professional values of Dr Mahlangu by which it would be medically best to continue and even increase the dosage of his medication. Akanya clearly understood Dr Mahlangu's concern about the high risk of relapse on cessation of medication and even his concern that his colleagues may disagree with him on his assessment of Akanya's current mental state. Akanya had no doubt that Dr Mahlangu would want him to continue with the medication.

As in the preceding indaba 8 years earlier, the key question that drove this indaba was: *how may (the story of) the decision account for the differences between respective values of Akanya and Dr Mahlangu without dismissing or changing the values of either?* Confronting this question conjointly and creatively, they made a shared decision that was the best in this specific values context even though not medically context even though not medically. They decided to discontinue the antipsychotic medication, while accounting for Dr Mahlangu's concerns by conjointly agreeing a plan to identify early a deterioration of his condition with an advanced agreement to revert to antipsychotic medication earlier rather than later. The outcome to date, 4 years on, has been good as evaluated by both. Being now without antipsychotic medication for this period, Akanya's condition has remained largely unchanged. Dr Mahlangu suspects that the relationship cemented with Akanya through this trying indaba may have helped therapeutically to avert a relapse.

21.9 Conclusions

Indabas as Akanya's story illustrates avoid a battle 'to persuade' without anyone sacrificing their values. Although framed by shared values, consensus on these did not, and could not, account for the legitimate differences of values among the stakeholders. The indabas rather exemplify dissensual decision-making where no one

had to change, compromise or sacrifice their values. All stakeholders could preserve what mattered to them in those specific circumstances. Dr Robertson and Dr Mahlangu did not relinquish what would be medically best, nor did they have to persuade Akanya or his parents to change or sacrifice their values as prerequisite to making a decision. The indabas afforded creative decisions that accounted not merely for what would have been best medically, but was instead best for the specific circumstances in which all stakeholders had legitimate values.

Without dissensual decision-making, Dr Robertson could have merely applied the MHCA. He had societal, professional and legal warrant to do so, but that indeed would have displaced the values of Akanya's parents as if not legitimate. Dr Mahlangu could have maintained that he had to do what was medically best, but that would have ruined the therapeutic relationship with Akanya. He could have tried to persuade Akanya to continue taking his antipsychotic, which would have set up both himself and Akanya for potential failure, usually labelled as non-adherence.

Alternatively, Dr Mahlangu could have argued that Akanya was not incapacitated by his mental disorder and he could decide for himself on whether to discontinue his antipsychotic medication. Dr Mahlangu could also have justified this in virtue of Akanya's legal status as being a voluntary mental healthcare user or as if so prescribed by the ethical principle of respect for personal autonomy. Although the merits of these justifications are not disputed here, note that without the dissensual decision-making, Dr Mahlangu's professional contribution would have been eroded and, importantly, also Akanya's participation in setting up sensitive arrangements to prevent a relapse early.

Thus, an indaba in the African version of values-based practice (A-VBP) holds in high regard differences of values. It caters for uncommon ground, even though framed within common ground. Doing so is premised on person-centred and interconnected-people orientations expressed in the African terms of "batho pele" and "ubuntu" [1, 4] reflected upon elsewhere [3, 7, 8].

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