COMMUNITY-BASED SUPPORT GROUPS FOR MENTAL HEALTH CARE USERS: A SOCIAL CONSTRUCTIONIST APPROACH

by

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Declaration

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I, Leana Meiring, declare that **COMMUNITY-BASED SUPPORT GROUPS FOR MENTAL HEALTH CARE USERS: A SOCIAL CONSTRUCTIONIST APPROACH** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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SIGNATURE   DATE

(MS L MEIRING)

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Dedication

I dedicate this study to all the group members with whom I have had the pleasure of working over the years. Your commitment to the group sparked my inspiration to embark on the research journey. I would also like to thank the research participants for their willingness to share their stories and experiences and allowing me to share it in this report. It is my hope that this study will encourage more supportive structures in community-based settings to assist those living with severe and chronic mental illness to live fuller lives as integrated citizens in their respective communities. Finally, I want to extend my appreciation to the Mental Health Care service providers who supported this initiative over the years; without your support this would by no means have been possible!

Abstract

High prevalence of mental illness in South African and limited Mental Health Care (MHC) resources call for ways to supplement the overburdened system to meet the rehabilitative and supportive needs of service users as stipulated in the MHC Act no. 17 of 2002. Various psychological, social, and financial difficulties plaguing MHC users require holistic treatment intervention to help them cope with their conditions. This study explored the meaning of a Tshwane District community-based support group for MHC out-patients to help illuminate the value the group had for the members. A Social Constructionist epistemology informed the qualitative research approach. Data were collected by conducting semi-structured interviews and employing a collage-making method. The main themes illuminated by thematic analysis suggest that the group provided the members with a sense of belonging, mental and physical mobilisation and stimulation, a source of support, multiple learning experiences, and contributed to personal transformation and growth.

Keywords: Primary Health Care; Community Health Centre; Mental Health Care Users; Mental illness; Community-based support group; Rehabilitation; Social support; Sitgmatisation; Social isolation; Intervention

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Chapter 1

Introduction, Background, and Research Outline

1.1   Introduction to the Research

The following pages portray a research account that was co-constructed between myself (the researcher) and the participants (the researched) informed by our combined journey. My interest to enquire into community-based social support for people living with severe and chronic mental illness was ignited by my involvement in a practical project during my Psychology Honours programme. My involvement in the project placed me in the role of co-facilitator of a support group for mental health care (MHC) users at a community-based Primary Health Care (PHC) centre. The project provided invaluable experience which bridged the gap between theory and practice and brought me face-to-face with the reality of living with a severe and chronic mental illness. After realising the multitude of challenges inherent in the consequences of mental illness and the lack of community-based rehabilitative and support structures currently available to MHC users, I felt compelled to explore a research topic that would contribute to this area within the South African context. Existing literature supported the value and need for community-based supportive and rehabilitative services to assist people with mental illness in recovering from the devastating effects of a diagnosis (Becker 2010; Becker & Duncan, 2010; Botha, Koen, Oosthuizen, Joska, & Hering, 2008; Sturgeon & Keet, 2010).

This chapter begins by setting the stage, providing background on the key 'players' in the research and the project on which the study was based. This is followed by the problem statement, purpose, and significance of the research. The study scope sets out to draw the study parameters, and my role and positioning in the research are described. The central

concepts are described before concluding with a brief overview of the chapters comprising this report.

1.2   Background: Setting the Context

While doing my Honours degree programme in 2010 at the University of Pretoria, I completed a community-based practical component that formed part of the Community Psychology module. A fellow student and I were assigned to the mental health care (MHC) unit of a Community Health Centre (CHC) in the Tshwane district (which I will refer to as a Tshwane District Community Health Centre or TDCHC). During our initial contact meeting with the MHC psychiatric nursing staff, they informed us that the TDCHC was in need of a social support group for the MHC service users who receive on-going psycho-pharmacological care at the centre to help them manage their stabilised chronic mental illness. They explained that all MHC centres are required to have a supportive structure in place for MHC service users. This forms part of the on-going community-based care, rehabilitation, and reintegration services this population is entitled to as stipulated in the Mental Health Care Act (MHCA), no. 17 of 2002, The Primary Health Care Package of South Africa - a set of norms and standards (South African Department of Health, 2000), and the National Mental Health Policy Framework and Strategic Plan 2013-2020 (South African Department of Health, 2012).

However, due to staff shortages and high patient load, which is a widespread problem in clinics and CHCs around South Africa (Lund et al., 2010b; Petersen et al., 2009), the MHC staff found it difficult to maintain the support group they had had in place previously. We were thus asked to assist them with the initiation and facilitation of a new support group.

The psychiatric nursing staff also explained that many of the MHC users who live with chronic stabilised mental illnesses, such as the service users they saw on a regular basis,

merely sit at home, are unemployed, and live off disability grants. The purpose of the group was thus to create a community-based space where MHC users living with chronic mental illnesses, who are socially isolated and alienated from society, could socialise and interact with others in similar situations.

Due to the MHCA's requirement for on-going community-based care, rehabilitation, and reintegration services, a slow-open support group was formed which allowed the group to continue indefinitely. According to Gildenhuys (2010) a slow-open group consisting of seven to nine members continues indefinitely by adding new members to the group as others complete their participation or decide to leave. This type of group seemed to be most suitable for the purpose of providing MHC users with an on-going social support structure within the community.

After our initial meeting with the MHC staff, they sent out an invitation to the identified population to voluntarily join the social support group. They personally invited service users whom they thought could particularly benefit from the group. They also understood the difficulties that service users experience with transport and invited those service users who lived within walking distance from the centre. Eight of the 12 service users who were invited attended the first group meeting. It was challenging to motivate the initial members to return to the weekly sessions and it took approximately two to three months for the core group to form.

The core group consisted of six to eight members who attended on a regular basis for the duration of the year from March to November 2010. The group met once a week for approximately 90 minutes. Members were heterogeneous with regard to their diagnoses which included Schizophrenia, Bipolar Mood Disorder, Major Depressive Disorder, and

Anxiety Disorder. The ages of the members of the group ranged from early twenties to late fifties.

Initially, a needs analysis was conducted with the group members to determine their unique needs and to hear their reasons for joining the group. The information gathered during the needs analysis was used to refine the group's purpose and to establish the group goals in line with the needs of the members to make it most relevant to their needs (Becker & Duncan, 2010). Some of the needs that were identified included: to learn about mental illness and medication; to learn about Tuberculosis; to learn about relationships; to get out of the house; and to play games. The group members decided which theme they wanted to discuss for each session and we (the facilitators) merely facilitated the group discussions and processes.

As we approached the end of the project, the members expressed a great need to continue with the group and we thus continued to facilitate the group processes for another year. My formal involvement with the group facilitation continued until the end of 2011. The group is currently still active and functioning with the assistance of student facilitators doing their practical component of the Community Psychology Honours module at the University of Pretoria. The facilitators are replaced each year by new students.

Over the years, new members have joined and left the group. Four of the core members have remained since the group's initiation. During 2013 the group consisted of five members who regularly attend group sessions and it was these five members who were invited to participate in the data collection.

It was this experience that sparked the research initiative. I became curious to know what value the members gained from attending the group sessions. Based on the group

discussions, it became clear that the members, who mostly suffered from severe and chronic

forms of mental illness accompanied by psychotic features, were alienated, stigmatised, and

discriminated against in their community. Ample literature confirms that this is also true for

other MHC users (Jones, 2009; Lund et al., 2010b; Petersen et al., 2009; Simpson &

Sambuko, 2011; Sturgeon & Keet, 2010). The group seemed to serve the purpose for social

interaction, providing a safe environment for the group members where they could interact

and bond with others who are in similar situations of isolation, loneliness, and alienation,

which is one of the functions of social support groups (Becker 2010; Sturgeon & Keet, 2010).

Throughout the initial stage of the formation of the group, the members appeared to

be nervous and shy. They did not interact or engage in conversation with one another before

or after the group sessions. During the sessions the members were reserved and did not speak

much. From what we observed as facilitators, it was evident that the group members did not

possess good communication or interpersonal skills. However, after the first year of

attending regular sessions, the members displayed significant improvements in their

communication and interpersonal skills and their general knowledge, as well as their self-

confidence. This was confirmed by the feedback we received from the group members

themselves as well as the MHC staff. The growth and changes that the group members

displayed, their commitment and dedication to the group, and the experiences they shared

during the group sessions, sparked my motivation for this research.

1.3   Problem Statement, Research Question, Aim, and Objective

South Africa has a high prevalence of mental illness which impacts immensely on the

country's disease burden (Freeman, 2012; Parker, 2012; South African Department of Health,

2012). Mental illness impacts negatively on the general functioning and quality of life of the

affected individuals. In addition, mental illness is associated with negative economic burdens in terms of direct costs associated with treatment and indirect cost incurred as a result of lost income associated with mental illness (Lund et al., 2011; Lund, Meyer, Stein, Williams, & Flisher, 2013; South African Department of Health, 2012). Due to the high patient load and staff shortages, the MHC sector struggles to meet the service requirements stipulated in MHC legislation and guiding documents, especially in community-based settings (Parker, 2012; Simpson & Sambuko, 2011). This calls for creative ways to supplement community-based MHC resources to help meet the supportive and rehabilitative service requirements of MHC users. Support groups could serve as a cost effective, culturally appropriate intervention to supplement the MHC service providers to meet the rehabilitative and support needs of service users in community settings (Becker & Duncan, 2010; Botha et al., 2008).

In light of the above, the research question was: What meaning did the group members attribute to the support group?

The aim of the research was to explore and describe the meaning that the community-based support group had for the group members in order to highlight the potential value of such groups for MHC users in other community-based settings.

The research objective was to explore the meaning the group had for the group members by reflecting on their group experiences. The participants' stories were used to provide evidence for the potential value of community-based support groups in assisting MHC users to reintegrate into their communities by offering them social support which could potentially improve their mental health and social well-being and help them to live richer more fulfilled lives despite their mental illness.

1.4   Purpose and Significance of the Research

The purpose of the research was to illuminate the meaning that the group had for the group members. This was achieved by means of a qualitative research approach. Rich descriptive data were elicited in two consecutive data collection phases by means of semi-structured interviews followed by a collage making and storytelling method. A thematic analysis was employed for the collected data to illuminate patterns in the datasets which represented the meaning that the participants attributed to the group.

The findings elicited from this research contribute to the paucity of research highlighting the value of community-based support groups for MHC users from the South African context (Becker & Duncan, 2010; Sturgeon & Keet, 2010). It provides further support of the importance of community-based reintegration and support services in assisting MHC users to maintain their mental health and well-being after being discharged from hospital or after receiving a diagnosis, which is in line with the recovery model advocated in the National Mental Health Policy Framework and Strategic Plan 2013-2020 (South African Department of Health, 2012). It is my hope that highlighting the value the group had for the research participants could help motivate MHC service providers and policy makers to consider making more such groups available in other PHC clinics and health centres around South Africa.

1.5   Study Scope, the Researcher's Positioning, and Reflexivity

This research set out to explore and describe the meaning that the group members ascribed to the social support group at a PHC community health centre within the Tshwane District. The study's findings merely illuminate the value of the group for those group members who participated in the data collection activities. Drawn from a small sample, the

findings are not meant to be generalised, but merely to contribute to the existing body of knowledge which highlights the potential value of such groups within the local context. It is also assumed the stories and reflections of the research participants represent their authentic experiences and opinions.

Due to my involvement with the group prior to the research and my long standing relationship with the participants, my positioning in this research took that of a dual role, namely of group facilitator and researcher. As the primary investigator, I was the main instrument in the data collection (Creswell, 2014). For the group members who participated in the research, I was their group facilitator. Although I would like to believe that they shared authentic memories and experiences, I cannot assume that my involvement in the data collection did not contribute to social desirability bias which coloured their favourable memories that were to be shared.

In an attempt to counter this, I adopted a social constructionist epistemology as a guiding framework for the study and offered reflections on personal biases and influences on the research outcomes. Social constructionism afforded value to my dual role and positioning as its main concern is the co-creation of meaning between people in social relationships (Burr, 2003; Du Preez & Eskell-Blokland, 2012). This approach thus allowed for a co-construction of the research between myself and the research participants. My role and positioning in the research as well as the guiding epistemology informed my choice for selecting a qualitative methodology and consequently the adoption of a first-person writing style. In fact, using first-person writing is considered necessary to adequately pursue reflexivity and is deemed appropriate in instances where the author is providing personal judgement deduced from reasonable evidence (Webb, 1992).

The findings presented in this report were undeniably influenced by my prolonged involvement with the research participants and our long standing relationship. Reflexivity was thus essential to make the extent of my influence apparent. Reflexivity is characterised by on-going self-disclosure and self-critique as the researcher describes their presence in the research and their influence on the various research decisions and interpretations throughout the research process (Koch & Harrington, 1998; Terre Blanche et al., 2008). It allowed me the opportunity to be sensitive to the ways in which my prior assumptions and experiences have shaped the different aspects of the research process and the collection of the data (Cooper & Endacott, 2007). Reflexivity was also a means to add to the trustworthiness of the findings and served as one of the measures to ensure the study's credibility (Creswell, 2014).

In qualitative research, the researcher is the primary instrument for collecting and analysing the data (Creswell, 2014; Terre Blanche et al., 2008). Reflexivity was therefore important as my focus was by no means value-free (Probert, 2006). My experiences, passions, beliefs, history, and interest were influential in driving this research venture. Some qualitative experts even believe that these are central to the interpretation and understanding of the phenomenon under investigation (Koch & Harrington, 1998). Quantitative scholars have used this argument as critique against qualitative research, claiming that the method is untrustworthy, impressionistic, strongly subject to researcher bias, and lacks scientific rigour (Denzin & Lincoln, 2011; Koch & Harrington, 1998). Qualitative researchers have addressed this critique with reflexivity. Insight into the topic of interest and familiarity with the research context are valued by the qualitative researcher, which are drawn from the researcher's background and personal experiences in order to gain a deeper understanding of the research phenomenon.

My experience with the group and the impact it had on me as well as the group members was the primary inspiration for this research. My extensive involvement with the group members and familiarity with the context placed me in a unique position as a researcher. My interpretations could not be separated from the interpretation of the data and, as mentioned, motivated the adoption of my social constructionist stance. The reflexive process allowed me to create some distinction between the participants' experiences and meaning and that of my own, allowing the reader to decide whether the final product was believable or plausible and conducted with rigour (Koch & Harrington, 1998).

1.6   Introducing Central Concepts

The following descriptions of the central concepts used in this report are briefly defined to highlight the meaning of the terms within the context of this study.

1.6.1   The group.

This refers to the community-based social support group that was established in March 2010 for the MHC users at a primary health care community health centre in the Tshwane district. The aim of the group was to offer psychosocial support and was not a therapeutic intervention. The group was co-facilitated by Psychology Honours students registered to study the Community Psychology module at the University of Pretoria. The continuity of the group has been made possible by assigning new student facilitators enrolling for the course each year and has been running since 2010 to 2015. The group setting or group context are additional terms used to refer to the group.

1.6.2 The group members.

The group members consisted of those MHC users (fluctuating between five to eight members at a time) who attended the group for an extended period ranging from six months to five years. Some members have been with the group longer than others. The members comprised the MHC service users who obtained their outpatient pharmacological treatment from the CHC. The group members were heterogeneous with regard to their diagnoses and ages, but most of them suffered with chronic and severe mental illness accompanied by psychotic features.

1.6.3 Mental health.

Mental health refers to a person's level of psychological well-being, either positive or negative, which could be affected by a range of social, physical, or psychological factors (MHCA, 2002).

1.6.4 Mental illness.

In the context of this research, mental illness is defined according to the definition in the South African Mental Health Care Act No.17 of 2002 as "a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health care practitioner authorised to make such a diagnosis" (Mental Health Care Act, 2002, p. 10).

1.6.5 Mental health care.

Mental health care refers to any care provided to a person diagnosed with a mental illness in either an inpatient or outpatient setting. It includes any intervention offered to assist with the improvement of symptoms or social well-being of individuals with a mental illness (South African Department of Health, 2000).

1.6.6   Community-based social support.

In the context of this study, community-based social support refers to services that are educative, empowering, and supportive in nature, aimed at assisting mental health care users to cope with their mental illness and to help them to improve their quality of life (Becker, 2010; Sturgeon & Keet, 2010). This includes providing information through psycho-education; offering a space where social and emotional support are offered and shared as well as providing opportunity for socialisation.

1.7   Chapter Outline

A brief description of the content of each chapter is furnished below.

Chapter 2 explores relevant literature related to the topic. It includes a review of South Africa's legislation and guiding documentation pertaining to the provision of MHC services as well as the PHC system and how MHC fits into this structure. It highlights the challenges faced by the MHC sector and the challenges faced by MHC users living with severe and chronic mental illness. Literature on support groups is reviewed to motivate the benefits of community-based support groups in assisting MHC users to reintegrate into community life and help them cope with some of the challenges they face on a daily basis.

Chapter 3 outlines the social constructionist epistemology and the guiding principles which informed the research. The qualitative research approach is outlined as well as the research design, data collection methods, and the thematic analytic techniques applied to evoke themes of meaning emerging from the collected datasets. Measures applied to ensure trustworthiness and ethical considerations are also discussed.

Chapter 4 describes the steps taken to prepare the datasets for the analysis process. I briefly reflect on the co-creation of meaning before introducing the research participants. The five main themes and sub-themes illuminating the meaning that the group members ascribed to the group are presented and discussed in light of existing literature.

Chapter 5 concludes the report with final reflections and remarks, the study's strengths and limitations, as well as the recommendations for future research.

1.8   Chapter Summary

This chapter introduced the reader to the topic by furnishing the background of the group and its initiation. The problem statement, research question, aim, and objective were subsequently set out. The research purpose introduced the methods that were applied in order to answer the research question followed by my motivation for the significance of this research. I described the scope by highlighting the study's parameters and declared my role and positioning in the research which supported my choice for adopting a social constructionist orientation. Central concepts were described followed by a brief overview of the chapters comprising this report.

Chapter 2

Literature Review

2.1   Chapter Overview

This chapter explores the legislation and guiding documentation that inform the planning, implementation, and provision of mental health care (MHC) services in South Africa. An outline of the South African health care system is furnished, as well as a discussion on how MHC fits into this structure. Literature regarding MHC is highlighted as well as the challenges faced by the country's health care system in general and specifically with regards to MHC. Thereafter, literature on mental health and MHC as well as the challenges MHC users face as a result of living with severe and chronic mental illness is reviewed. Finally, I argue how support groups can be utilised as potential community-based rehabilitative and support services to assist MHC users to reintegrate into community life and help them cope with some of the challenges they face on a daily basis.

2.2   South African Mental Health Care Legislation and Guiding Documentation

When the democratic government came into power in 1994, the country's health care system was subjected to major change and transformation. A Primary Health Care (PHC) philosophy was adopted by the new government (Cullinan, 2006; Jones, 2009; Petersen et al. 2009). This involved a shift away from the doctor-dependent curative treatment model towards a system which focuses more on disease prevention, health promotion, and rehabilitation from illness and health problems (Burns & Esterhuizen, 2008; Cullinan, 2006; South African Department of Health, 2012).

The PHC philosophy values the following concepts: ensuring universal coverage of care for the entire population according to the needs of the service users; providing services that are promotive, preventative, curative, and rehabilitative in nature; and providing services that are effective, culturally acceptable, manageable, and affordable. Furthermore, the services are aimed at community development and community participation in the planning, provision, control, and monitoring of health services to reduce dependence, and promote self-reliance of service users (Cullinan, 2006; Sokhela, 1999).

The post-apartheid health care system followed the worldwide trend towards deinstitutionalisation by making specialised health services available in community settings (Lund et al., 2010b; Sturgeon & Keet, 2010; South African Department of Health, 2012). This transformation called for a major revision of the country's mental health legislation which led to the development of South Africa's first post-apartheid mental health policy in 1997 entitled the "National health policy guidelines for improved mental health in South Africa" (Lund, Kleintjes, Kakuma, Flisher, & MHaPP Research Programme Consortium, 2010a; WHO, 2007).

Due to the absence of formal dissemination processes, a monitoring system, and action plan for putting these guidelines in place, this policy was unfortunately never published for dissemination and was never implemented on a national level (The Mental Health and Poverty Project, 2008; South African Department of Health, 2012). As a result, for a number of years, South Africa lacked an official mental health policy guiding the implementation of the Mental Health Care Act (MHCA) (2002) which prescribes how to provide care, treatment, and rehabilitation to people who are considered to suffer from mental illness (South African Department of Health, 2012; WHO, 2007). The absence of a mental health policy meant that there was no action plan in place to guide government officials and

service providers to ensure that the objectives and laws advocated in the MHCA were put

into action. Literature highlights that in many instances these laws were indeed not being

implemented for a multitude of reasons which are discussed later in this chapter (Lund et al.,

2010b). However, this situation is likely to change following the recent implementation of

the National Mental Health Policy Framework and Strategic Plan 2013-2020 by the National

Health Council in July 2013 (Stein, 2014).

The main objectives stipulated in the MHCA (2002) advocate the right of MHC users

to have access to care, treatment, and rehabilitation services which will serve their best

interest. Furthermore, these services should be made available within the limits of the

available resources. The Act also stipulates that every organ of state responsible for

providing health services, for example, the TDCHC at which this research was conducted,

must determine and co-ordinate the implementation of its policies and measures in a manner

that ensures the availability of MHC treatment and rehabilitation services at the various levels

of the health system (primary, secondary, and tertiary), as well as at health establishments.

This suggests that every clinic and CHC is responsible for the promotion and the availability

of community-based care, treatment, and rehabilitation services for MHC service users. The

support group described in this research can serve as an example of a viable community-

based support and rehabilitative service. The group initiative brought about improvements in

the interactional and communication skills of the group members over their prolonged

involvement and participation in the group activities and processes. The themes developed

from the participants' interviews will further highlight how the group benefitted the group

members.

The MHCA (2002) further advocates for the equal provision of mental health services

as a part of primary, secondary, and tertiary health services to all who require it. This is

stipulated in Chapter II of the MHCA (2002) as one of the objectives, which is to promote the

integration of MHC services into PHC facilities. These objectives also fall in line with The

Constitution of South Africa, Act 108 of 1996, which prohibits the discrimination of any

form against any persons. In the light of this, MHC users have the right to have access to

community-based treatment, care, rehabilitation, and support services to serve their best

interest. Failing to provide such services can be considered unconstitutional (Cullinan,

2006).

The Primary Health Care Package of South Africa, a set of norms and standards

(South African Department of Health, 2000), is a document that was drawn-up by a national

task team from the Department of Health's Quality Assurance Directorate and various other

role players (Cullinan, 2006; South African Department of Health, 2000). The document

outlines the range of health services that should be available and prescribes the acceptable

standards of services which are to be rendered to service users in the PHC setting (South

African Department of Health, 2000). The document is to be used by health care service

providers to inform them of the quality of the services they should strive to render, and by

health care service users informing them of the level of services they can expect to receive at

health establishments. The document is also meant to inform district and provincial service

planners to help them identify the unmet needs of the service users and to assist the processes

of resource allocation.

Similar to the MHCA (2002), this document prescribes that mental health services

must be integrated into the PHC setting and that services should be of such a nature that they

will assist service users to improve their mental health and social well-being (South African

Department of Health, 2000). The document also highlights that the continuity of services is

considered to be a standard patient right. The norms and standards regarding MHC that resonate with this research are discussed next.

Firstly, PHC services are mainly rendered by nurses, but the norms declare that there should be periodic access to MHC specialists, for example psychiatrists, at least once a month (South African Department of Health, 2000). Secondly, the staff should further maintain on-going follow-up visits, preferably with a consistent member of staff, to ensure that patients who are living with chronic, stable mental illness manage their symptoms and adhere to treatment plans. This can be achieved only by means of in-depth and thorough follow-up interviews which aim to assist with the early recognition of distress or possible relapse. Thirdly, the document prescribes that MHC users are to receive on-going follow-up care to help them maintain an optimal level of functioning and social integration. This includes educating patients, their families, and communities in understanding mental illness and mental health. Lastly, with regard to community activity, the norms prescribe that staff should encourage both patient and caregiver support groups in the community and that collaborative partnerships with relevant role players are to be encouraged in order to assist in meeting all service demands (South African Department of Health, 2000). These norms and standards as indicated here fall squarely on the shoulders of the psychiatric nurses who are already struggling to deal with the high patient load. This calls for the creation of supportive community-based interventions that will address these norms and standards without placing further demands on the already overburdened MHC nurses.

Support group initiatives can be regarded as a means to adhere to these prescribed norms within the limits of the available resources. Such services can help address the unmet supportive and rehabilitative needs of service users at their local PHC facilities. The nature of support group services is appropriate for providing continuous follow-up care for MHC

users and holds the potential to bring about improvements in their mental health as well as their social well-being and quality of life, which falls in line with the recovery model advocated in the Mental Health Policy Framework (South African Department of Health, 2012).

The above section outlined the primary tenets advocated in the country's mental health legislation and official documents such as The Primary Health Care Package of South Africa - a set of norms and standards (South African Department of Health, 2000). An overview of the South African Health Care System follows to indicate how MHC services fit into the health care structure.

2.3   The South African Health Care System

South Africa's health services and budgets have been decentralised to fall under the nine provinces which are further divided into 53 health districts following the decentralisation of MHC services to be incorporated into PHC (Cullinan, 2006; WHO, 2007). The decentralisation of health services formed part of the greater national plan to make health services equally available to all citizens and an attempt to rectify the inequalities of the apartheid system (Jones, 2009; South African Department of Health, 2012; Sturgeon & Keet, 2010). The current health care system works in terms of a hierarchy of which clinics and CHCs are the first level of entry (Cullinan, 2006; Lund et al., 2010b).

Service users who do not need hospitalisation (ambulatory patients) are required to seek treatment from clinics and CHCs. These are classified as primary level services (Cullinan, 2006). Clinics and CHCs differ in terms of the availability of emergency and maternity services and operating hours. Clinics operate eight hours a day, five days a week. CHCs on the other hand are required to also offer 24 hour emergency and maternity services

and to have a number of inpatient beds available for patient observation. If more specialised

care is required, patients are referred to either district (level 1), regional (level 2), or tertiary

(level 3) hospitals depending on the unique patient needs (Cullinan, 2006).

Lund et al. (2010b) explained that there is a specific service utilisation pathway for

MHC users in South Africa. Service users who seek first time treatment for mental illnesses

are expected to visit a clinic or CHC (South African Department of Health, 2012). The

MHCA (2002) prescribes that MHC users receive treatment primarily at primary (clinics and

CHCs) and secondary (district hospitals) levels and that tertiary care (specialised hospitals) is

merely a last resort. This means that MHC users should be referred to a psychiatric hospital

(a tertiary care facility) only if they cannot be effectively treated at a clinic, CHC, or a district

hospital. Sturgeon and Keet (2010) further indicate that after South Africa has moved

towards decentralisation of MHC services into the PHC system in community settings,

psychiatric hospitals are to provide care for only the acutely ill.

Weskoppies Psychiatric Hospital, situated in Pretoria West, is classified as one of the

country's 25 psychiatric hospitals (South African Department of Health, 2010). Many of the

group members have been admitted and readmitted to this local tertiary care facility since

receiving their diagnoses. It is important to note that the number of hospital beds in

psychiatric hospitals such as Weskoppies Hospital has been on the decrease since 2002 as a

result of the decentralisation efforts (Botha et al., 2008; WHO, 2007). Unfortunately, the

resources required to create and sustain community-based MHC services did not follow the

consumers into the communities and as a result there is a great need for additional human

resources in order to meet the service demands of MHC users within the PHC setting (Botha

et al., 2008; South African Department of Health, 2012; Sturgeon & Keet, 2010). It is

therefore of paramount importance to assist MHC users to manage their symptoms, adhere to

their treatment plans, and to integrate successfully into their communities once discharged

from hospital or after obtaining a diagnosis for a mental illness. Community-based social

support systems such as support groups can assist MHC users to adjust and reintegrate into

community life once they have been discharged from hospital and help them manage their

symptoms. This is further discussed later in this chapter.

The HIV/Aids pandemic and staff shortages have been identified as the two biggest

issues plaguing the country's health care system. MHC services are by no means left

unaffected by these issues (Cullinan, 2006; WHO, 2007). Other serious problems

experienced in the PHC sector which affect MHC services include: large patient loads; poor

working conditions; high staff turnover; and the fact that the PHC working environment is

not an attractive career option for qualified nurses (Botha et al., 2008; Cullinan, 2006;

Petersen et al., 2009). Petersen et al. (2009) explained how MHC service providers at PHC

institutions are often required to assist with general health services, neglecting the service

needs of MHC users and that trained PHC nurses are not always available to manage

psychiatric patients as a result of high staff turnover in this sector.

In my opinion, the community-based support group initiative described in this

research has served as a creative solution to supplement the human resources shortage at the

PHC level to help meet the service demands (specifically rehabilitative and supportive

service needs) of MHC users at this TDCHC. In the light of this, the literature regarding

mental health and MHC in South Africa is now examined and I argue why community-based

social support groups can be a viable, culturally appropriate, rehabilitative and supportive

service option that can be used to assist the overburdened MHC system to meet the

rehabilitative and supportive service demands of MHC users as advocated in the MHC

legislation and policy guidelines.

2.4   Research on Mental Health and Mental Health Care in South Africa

South Africa has a high lifetime prevalence of mental illness which is a major contributor to the country's high burden of disease (Parker, 2012; South African Department of Health, 2012; Williams et al., 2008). Freeman (2012) reported on research using a nationally representative sample which indicated that the lifetime prevalence of psychological disorders among South African adults was found to be approximately 30.3%. Further supporting this, Stein et al. (2008) pointed out that there are a number of reasons to believe that the occurrence of mental illness in the country might be high. South Africa has a long history of political violence and inequality. After two decades of democracy various social ills such as poverty, unemployment, crime, and violence still jeopardise the social and emotional well-being of numerous citizens (Becker, 2010; Petersen et al., 2009; South African Department of Health, 2012).

Even with the common incidents of mental illness in the country and the strain the HIV/Aids pandemic places on the health care system and indirectly on MHC services, South Africa remains resource poor with regards to MHC. These services are hugely underdeveloped which results in a high level of unmet needs of MHC users (Lund et al., 2010b; Parker, 2012; Petersen et al., 2009; Williams et al., 2008). Simpson and Sambuko (2011) verified that resources for MHC users are especially limited in townships. They also pointed out that MHC users who have been discharged from hospitals often receive almost no services. This, in turn, places an excessive burden on the MHC users and their families (Simpson & Sambuko, 2011).

It is evident that there is a great need for the creation of additional mental health care, treatment, and rehabilitation resources in South Africa (Patel, Saraceno, & Kleinman, 2006; Petersen et al., 2009). More specifically for the development of community-based resources

to meet the service needs of MHC users in terms of the mental health care, treatment, and rehabilitation services to which they are entitled, according to South African health care legislation (Lund et al., 2010b; Sturgeon & Keet, 2010).

Botha et al. (2008) explained that the paucity of residential homes and day-care services is a major obstacle to successful community-based treatment in South Africa. In addition to this, the reduction of long term beds in psychiatric hospitals following the decentralisation of MHC services forces the premature discharge of MHC users who have been stabilised but still require further hospitalisation. These service users are discharged into their community where there are limited support services. This places a tremendous burden on their families and in turn increases the probability for relapse (Simpson & Sambuko, 2011). This situation contributes to the revolving door phenomenon which refers to individuals who are frequently admitted to hospitals and remain well for short periods in the community before being readmitted to hospital (Botha et al., 2008; Botha et al., 2010).

Sokhela (1999) examined the integration of MHC services into the PHC system and also found that rehabilitation services for MHC users after hospitalisation were limited within the Eastern Cape study area. Sokhela (1999) further emphasised the need to develop and test implementation plans that are practical and effective in the local context. Similar research by Petersen et al. (2009) reported that South Africa's process of deinstitutionalisation and integration of MHC services into PHC remains limited to the emergency management of psychiatric patients and the psycho-pharmacological treatment of mental illness. In a more recent article, Parker (2012) echoed the overreliance on medication and large institutions in efforts to treat mental illness.

There is indeed no shortage of literature (Botha et al., 2008; Lund et al., 2010b; Patel et al., 2006; Petersen et al., 2009; Simpson & Sambuko, 2011; Sturgeon & Keet, 2010) that highlights the need to create and implement viable solutions to the many problems and shortcomings in meeting the service needs of MHC users. Cullinan (2006) reminds us that the South African health care system is complex and addressing the multitude of problems with its transformation will prove to be challenging. It is therefore imperative for all service providers and stakeholders with an interest in MHC to unite and combine efforts if we are to improve the current state of MHC services in the country (Parker, 2012). The following section will highlight the difficulties faced by MHC users as a result of their mental illness to justify the urgent need for health care professionals to address their neglected service needs.

2.5   The Impact and Effects of Mental Illness on Mental Health Care Users

Mental illness can cause havoc for affected individuals and their loved ones. The majority of the disorders classified in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5™) cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (American Psychiatric Association, 2013). Psychosis, which commonly accompanies the Schizophrenia Spectrum Disorders and severe cases of Bipolar Related or Depressive Disorders, refers to a break in a person's contact with reality (APA, 2013; Jordaan, 2012). Psychosis can feature any of the following primary symptoms: delusions; hallucinations; disorganised speech; abnormal psychomotor behaviour; and negative symptoms such as diminished emotional expression (flat affect), a decrease in motivated self-initiated purposeful activities (avolition), diminished speech (alogia), a decreased ability to experience pleasure (anhedonia), or a lack of interest in social interaction (asociality) (APA, 2013). All of these symptoms cause severe impairments in the affected person's functionality of normal life activities, for example, recreational and

work related activities. In support of this, Shrivastava, Johnston, Thakar, Stitt, and Shah

(2011) reported low levels of social productivity and social isolation among research

participants diagnosed with Schizophrenia in their naturalistic ten-year follow-up study.

Moreover, research indicates that many people with mental illness experience problems with

finding and keeping employment, which result in boredom and increased social isolation

(Drake & Whitley, 2014; Matthews, Harris, Jaworski, Alam, & Bozdag, 2013). This in turn

affects MHC users' adaptability to social life, leaving them alienated from society which can

be more painful than the disorder itself (Fleury, Grenier, Bamvita, & Tremblay, 2013a). This

also contributes to MHC users being excluded from normal everyday social activities or

events such as spending time with friends or celebrating birthdays. This deprives MHC users

from experiencing a sense of normality which in turn negatively impacts on the recovery

journey (Buchanan, Peterson, & Falkmer, 2014; Drake & Whitley, 2014).

Stanghellini and Lysaker (2007) explained how people with Schizophrenia, a severe

and chronic disorder, experience tremendous difficulties with meaningfully engaging with

people and the world. People who suffer from Schizophrenia have been found to experience

themselves as absent from the world and relationships with others; as having diminishments

in their self-experience and a loss of their sense of self, resulting in compromised first- and

second-person awareness. As a result, people with Schizophrenia may experience

relationships from the third person perspective. Stanghellini and Lysaker (2007) proclaimed

that social dysfunction is a core feature of Schizophrenia. Research by Fleury et al. (2013a)

confirmed this by highlighting that people with severe mental illness expressed a great need

for interpersonal relationships.

Other chronic and severe disorders such as Bipolar Related disorders, Depressive, and

Anxiety related disorders can leave affected individuals severely distressed and in turn reduce

the quality of the person's life as it impairs a person's functioning (Burke, 2012; Lake, 2012). Simpson and Sambuko (2011) further explained how the lack of social skills of many MHC users due to their mental illness, may hamper their ability to make friends which in turn contributes to their loneliness and social isolation. As a result, people with severe mental illness often have smaller social networks which are less reciprocal and may contain more MHC professionals (Tsai, Dasai, & Rosenheck, 2012).

Literature also indicates that individuals living with mental illness experience discrimination, isolation, and endure considerable levels of stigma (Hayne, 2009; Siyabulela & Duncan, 2006; South African Department of Health, 2012; Sturgeon & Keet, 2010). This is even more so for those people who suffer from severe forms of mental illness and present with psychotic symptoms that are more noticeable, and as a result they become more stigmatised. Barlow and Durand (2009) assert that people with severe mental illnesses are twice as likely to be subjected to public harassment in comparison to people without. In more recent local research, Simpson and Sambuko (2011) pointed out that people with mental illness are stigmatised and isolated as many people do not want to associate themselves with mentally ill people. Furthermore, the mental impairments resulting from mental illness and the side-effects that may result from medication can cause MHC users to demonstrate strange behaviours and unusual appearance which further contribute to their alienation and stigmatisation (Sturgeon & Keet, 2010).

Mental illness is commonly associated with a range of negative perceptions and beliefs (Arboleda-Flórez & Stuart, 2012; South African Department of Health, 2012). The widespread belief that people with mental illness are dangerous and unpredictable impacts negatively on MHC users living with chronic or severe mental illnesses and also contributes to the isolation and lack of support of those diagnosed with mental illness (Jones, 2009;

Jordaan, 2012; Nsereko et al., 2011; Stuart, 2003). Furthermore, the attributions regarding the aetiology of mental illness according to the African perspective also entails negative connotations for example being bewitched or being punished by the ancestors for doing something wrong (Burns, Jhazbhay, & Emsley, 2011; Mzimkulu & Simbayi, 2006). These negative consequences accompanied by mental illness illuminate the importance for effective treatment, rehabilitation, and supportive efforts to assist MHC users to continue with their lives as normally as possible after receiving a diagnosis.

2.6   Treatment and Rehabilitation of Severe and Chronic Mental Illness

The difficulties that MHC users face as a result of their mental illness extend far beyond their symptoms. Mental illness negatively impacts on a person's general functioning, motivation, and ability to set goals (Malchow et al., 2013; Snethen, McCormick, & Van Puymbroeck, 2012). It is thus important to assist these individuals to deal with life in their communities after receiving a diagnosis and not to merely treat their symptoms with medication (Sturgeon & Keet, 2010). Some of the common difficulties that MHC users experience include: job loss; difficulty finding accommodation; loneliness; becoming isolated; impaired cognitive and social functioning; and a lack of social, emotional, and financial support (Mathews et al., 2013; Moriarty, Jolley, Callanan, & Garety, 2012; Rajji, Miranda, & Mulsant, 2014; Simpson & Sambuko, 2011). All too often, treatment plans are primarily concerned with the treatment and management of symptoms, thus neglecting the importance of psychosocial rehabilitation.

2.6.1   Pharmacological treatment.

Pharmacological treatment has been the traditional clinical approach for treating mental illness (Botha & Du Plessis, 2012). Antipsychotic medications are used to treat

psychosis found in people with Schizophrenia Spectrum Disorders and people displaying

psychotic features (Barlow & Durand, 2009; Sadock & Sadock, 2007). However, in cases

where these medications do prove to be effective, it is mainly effective in treating the positive

symptoms (delusions and hallucinations) and to a lesser degree the negative symptoms and

functional impairments caused by mental illness. Furthermore, for medication to work

effectively, it has to be taken as prescribed. However, psychiatric medications are usually

accompanied by unpleasant and undesired side effects, causing many to not adhere to their

prescribed pharmacological treatment plans (Castelein et al., 2008).

Side-effects commonly reported by MHC users include tiredness, sleepiness, or even

nausea (Simpson & Sambuko, 2011). Some of the physical symptoms that may be caused by

antipsychotic medications include grogginess, blurred vision, and dry mouth (Barlow &

Durand, 2009). More serious and distressing side effects of antipsychotic medication may

include: shaking and trembling; expressionless face; slow motor activity; monotonous

speech; and involuntary movements of the tongue, face, mouth, or jaw. Many of these side

effects were observed by the facilitators among the group members.

2.6.2   Psychosocial interventions.

Due to the complexities of mental illness and the various aspects it affects in an

individual's life and functioning, medication alone is not effective in treating mental illness

holistically (Barlow & Durand, 2009; Sturgeon & Keet, 2010). There is a wealth of literature

that highlights the importance of psychosocial interventions (such as support groups) in the

effective treatment and management of severe cases of mental illness in conjunction with

pharmacological treatment (Chadzynska & Charzynska, 2011; Fontao & Hoffmann, 2011;

Katakura, Matsuzawa, Ishizawa, & Takayanagi, 2013; Meyer, Johnson, Parks, Iwanski, &

Penn, 2012; Sadock & Sadock, 2007; Sturgeon & Keet, 2010). Examples include services

which offer support to regain general functionality, supportive services to help MHC users

cope with stigma and social isolation, and physical exercise as add-on treatment which has

been shown to reduce symptomology and has a positive effect on cognitive functioning

(Malchow et al., 2013; Vancampfort et al., 2012). All of these services could be offered in

group settings. Within the context of support groups, people suffering from mental illness

can be re-taught the social skills such as basic conversation, assertiveness, and relationship

building which are impaired as a result of severe disorders.

Furthermore, social support groups can help MHC users to better understand their

disease and symptoms and they can learn how to manage their lives better by sharing

personal experiences and through giving each other advice and peer support (Anderson,

2013; Castelein et al., 2008; Sadock & Sadock, 2007). Support groups can also provide

resources for dealing with the emotional and practical challenges that sufferers face on a daily

basis (Barlow & Durand, 2009; Walstrom et al., 2013). More specifically, research

conducted by Meyer et al. (2012) as well as Fontao and Hoffmann (2011) provided support

for the effectiveness of psychosocial support in improving the negative symptoms associated

with Schizophrenia as well as improving the well-being and quality of life for those suffering

from this severe and persistent mental disorder. Botha et al. (2008) indicate that the sustained

support of MHC users in the community is essential to ensure the maintenance of positive

mental health outcomes.

It is evident that medication can be effective for the treatment and management of

symptoms, but it is equally important to offer rehabilitation and supportive services in

conjunction with medication to assist MHC users regain lost or never learnt skills which can

help them to normalise relationships with their environment, people, and situations in general (Sturgeon & Keet, 2010).

2.6.3   Rehabilitation.

South African health care legislation advocates services that include a rehabilitative focus. Despite this focus, literature indicates that local psychosocial rehabilitative services are still under developed or completely absent in certain areas (Peterson et al., 2009; Simpson & Sambuko, 2011).

Gildenhuys (2010) and Jones (2009) specifically stressed the importance of community-based psychosocial support and rehabilitation services for MHC users living with severe, chronic mental illnesses. Social support services can help these individuals cope with the negative impacts of these conditions on their personal, social, and occupational functioning (Keen & Barker, 2009; Stanghellini & Lysaker, 2007; Sturgeon & Keet, 2010). Simpson and Sambuko (2011) pointed out that there is a significant link between good social support and the perceived quality of life for this population.

Psychosocial rehabilitation goes beyond mere symptom control and management. Instead, it focuses on the long term recovery, self-sufficiency, and assisting MHC users to successfully integrate into their communities after being hospitalised (Simpson & Sambuko, 2011). The focus of psychosocial rehabilitation is thus on recovery, empowerment, competency, and assisting MHC users to become more independent and confident in functioning within their communities as contributing citizens (Simpson & Sambuko, 2011; South African Department of Health, 2012). Psychosocial rehabilitation includes skills training and community support that may help MHC users function and cope better in social,

vocational, educational, and familial roles with the least amount of supervision from helping professionals.

Parker (2012) argued for the implementation of a recovery framework within South African mental health services and for promoting a new understanding of recovery as critical in addressing the country's high burden of disease. The recovery framework is also advocated in the National Mental Health Policy Framework and Strategic Plan 2013-2020 (South African Department of Health, 2012). Recovery is more than the cure or absence of illness but involves healing from the devastating effects of mental illness and reaching one's full potential in order to live a meaningful life (Parker, 2012; South African Department of Health, 2012). It is thus essential for rehabilitative efforts to focus on social and psychological aspects in addition to medical aspects such as psycho-pharmacological treatments which seem to be the primary focus of MHC services at the moment.

According to Simpson and Sambuko (2011), the current psychosocial rehabilitation policy for South Africa is being drafted and it supports a recovery based perspective with a focus on social reintegration of people with mental health issues. Sturgeon and Keet (2010) described the concept of reintegration to include a state of positive mental health in which MHC users experience a sense of well-being and are able to actively participate in satisfying relationships and contribute meaningfully to their communities. The MHCA (2002) also refers to the concept of mental health in a similar manner. Support groups have shown to assist MHC users to reintegrate into their communities (Meyer et al., 2012; Sturgeon & Keet, 2010). It is my hope that this research will serve as further support of the benefits of community-based social support groups for MHC users on their recovery journeys.

2.7   Support Groups as a Creative Solution

Community-based group work (such as support groups) can be utilised as a viable solution to assist with meeting the psychosocial rehabilitative and supportive service needs of MHC users in keeping with the policy advocated in the South African MHC legislation (Becker, 2010; Simpson & Sambuko, 2011). This can be achieved through assisting MHC users to reintegrate into community life. Group work has been identified as an effective way to help improve the quality of life of MHC users by serving as a medium to empower service users with the necessary knowledge, attitudes, and skills required to live a life of quality in their respective communities (Becker, 2010; Fontao & Hoffmann, 2011).

Much research has been published on the effectiveness and usefulness of support groups in the treatment and management of mental illness both in inpatient and outpatient settings (Fontao & Hoffmann, 2011; Meyer et al., 2012; Schneider Corey, Corey, & Corey, 2014; Yalom & Leszcz, 2005). Becker and Duncan (2010), however, highlighted that little has been published on culturally appropriate group work within the South African context. Becker (2010) highlighted that group work fits in well with the customarily used models of help among African cultures which is more focused on the collective than the individual as it uses the power of the collective to assist the individual. Support groups can thus be considered to be a culturally appropriate community-based rehabilitative and supportive resource to be used in clinics and CHCs for MHC users of African origin in their respective communities.

Moreover, the value and usefulness of groups in hospital-based settings are well documented. However, a paucity of research that recognises the use and value of community-based groups in terms of MHC within the local context remains (Sturgeon & Keet, 2010). It is in this area to which I wish to contribute.

Sturgeon and Keet (2010) provides a comprehensive description of community-based support groups within the South African MHC setting. They explain that these types of groups fluctuate and vary in terms of size, but that they are usually better containable if the group is limited to a maximum of 12 members.

Furthermore, community-based groups should be open groups. Open groups allow members to leave if they choose, but also provide them with the assurance that they may return should they feel the need to do so. Open groups are of such a nature that they continue indefinitely with changing members (Gildenhuys, 2010; Yalom & Leszcz, 2005). These types of groups are therefore suitable for the provision of on-going community-based support services to MHC users in outpatient settings such as clinics and CHCs. Open groups have been found to be sustained more effectively in outpatient settings and are therefore preferred to closed groups (Yalom & Leszcz, 2005).

Community-based support groups have also shown to work well if members are heterogeneous with regards to age, race, culture, or diagnosis. Sturgeon and Keet (2010) proclaim that the heterogeneous composition has proven to be empowering in the sense that members discover or develop new found skills and even take on new roles in relation to each other, for example, as group leader or carers. They do, however, point out that it is important for group members to share common goals. Furthermore, it is better if the group meetings are conducted within walking distance from the residences of the members as transport problems might make it difficult for members to attend regularly.

Due to the limited psychosocial rehabilitative and supportive services available to MHC users, it is suggested that group work should focus on MHC users' adjustment to life in the community (Simpson & Sambuko, 2011; Sturgeon & Keet, 2010). Thus, the facilitator

need not be a MHC professional, but can be anyone who is trained or experienced in group

processes. It is however important for the facilitator to establish good networks with relevant

MHC professionals in order to refer patients for treatment when they do need psychiatric

intervention.

In terms of their purpose, support groups should be educative, empowering, and

supportive in nature and should assist MHC users to improve the quality of their lives

(Becker, 2010; Sturgeon & Keet, 2010). The facilitator should direct the group agenda

according to the unique needs of the group members. Furthermore, it is the facilitator's role

to encourage attendance and to model appropriate social behaviour to members whose

confidence and skills needed for social interaction are impaired as a result of their mental

illness (Simpson & Sambuko, 2011; Yalom & Leszcz, 2005). The facilitator should inform

and allow the group to take responsibility for the group processes which is important bearing

in mind the disempowerment and stigmatisation that the members have most likely

experienced as a result of their mental illness (Sturgeon & Keet, 2010).

The facilitator should assist the group to establish group norms which are important

for containing members and to help facilitate constructive group processes (Yalom & Leszcz,

2005). Group norms may include concepts such as: regular attendance; punctuality; respect

for one another; to be free of substances when attending the group; to respect confidentiality;

and to maintain personal hygiene that is acceptable to the group.

Group facilitators are in a position to assist group members to identify their personal

goals as their ability to set their own is often impaired as a result of their mental illnesses

(Schneider Corey et al., 2014; Sturgeon & Keet, 2010). This empowering process is linked to

the strength-based approach of mental health treatment. Jones (2009) echoes the value of the

strengths-based approach of social competence with regards to the treatment and

management of mental illness, particularly amongst African service users. She identifies

these as central concepts to enhance and improve the psychological well-being of culturally

diverse groups in mental health treatment. Furthermore, psychosocial competence

encompasses skills, knowledge, and qualities that enable a person to function effectively and

contribute meaningfully to society (Jones, 2009).

In addition, support groups provide members with an opportunity to socialise (Becker,

2010). Individuals with mental illness often find it incredibly difficult to interact with others

as a result of their conditions (Simpson & Sambuko, 2011; Stanghellini & Lysaker, 2007).

They can find themselves trapped in a cycle of isolation, low self-esteem, and emptiness,

which might hamper their desire and ability to connect with others. Group facilitators are in

a position to encourage group members to develop appropriate social skills and to move

beyond the preoccupation with themselves, once they are comfortable within the group

setting (Stanghellini & Lysaker, 2007; Sturgeon & Keet, 2010).

I mentioned earlier that extensive evaluation of MHC users' mental states forms part

of the routine follow-up service package. Due to the high case loads and staff shortages,

MHC service providers find little time for extensive interviews which compromises the

quality of their services that are necessary to exert a positive impact on the morbidity of

MHC service users (Botha et al., 2008). Community-based support group facilitators are in

an ideal position to help monitor the group members' symptoms and treatment adherence.

This is a good example of how community-based support groups can serve as a creative

solution to assist the human resource crisis in the PHC sector to help meet the service

demands of MHC service users.

Botha et al. (2008) pointed out that it is important to find cost effective ways with which to supplement the overburdened MHC system. This should be carried out by providing services to facilitate the existing services. In line with this, Petersen et al. (2009) mentioned that there are potential MHC service providers in tertiary training institutions that can be utilised in creative ways to serve as a supplementary human resource to the overburdened health care system. These individuals can be used as support group facilitators for MHC users at community clinics and CHCs as was the case with this initiative at the University of Pretoria.

2.8   Chapter Summary

This chapter furnished an outline of the South African mental health care legislation and policy as well as the South African health care system. Research on mental health and mental health care in South Africa was discussed as well as the impact and effects of mental illness on MHC users and the treatment and rehabilitation of severe and chronic mental illness. Finally, I demonstrated support for the use of support groups in meeting the community-based psychosocial rehabilitative service needs of MHC.

Chapter 3

Methodology

3.1   Chapter Overview

This research set out to explore the meaning that the support group had for the participating group members. In order to inform a co-constructive research report which illuminated this meaning, I searched for an appropriate research method and tools to obtain, document, and construct the participants' stories of their group experiences. This chapter covers the guiding epistemology which informed the research process. It also outlines the specific steps of the method taken to conduct the research and analyse the data. Furthermore, it provides the measures to enhance the trustworthiness of the results as well as the ethical considerations.

3.2   Introduction

Literature portrays several paradigmatic schemas available in the field of psychological research. Various authors present different paradigmatic classification schemas which can inform research (Jordaan, 2010; Ponterotto, 2005; Terre Blanche & Durrheim, 2008). It is important to note that each paradigm has unique ontological (concerning the nature of reality and being) and epistemological (concerning the study of the nature of knowledge and knowledge acquisition) assumptions which guide and inform research processes. Each paradigm consists of a unique set of concepts and assumptions which depict a particular perspective of reality, view of what a person is, and what governs experiences, perceptions, and behaviours (Burr, 2003; Jordaan, 2010; Ponterotto, 2005).

Jordaan (2010) emphasised that each of these approaches (each offering a different angle from which to look at the world and people) are equally valid in their own right, but are not equally *useful* in terms of the function they fulfil for a particular research aim. It is the responsibility of the researcher to choose the most appropriate approach best suited for the aim of the particular research. With this in mind, I carefully considered the research aim (to explore the meaning the group had for the group members), my relationship with the participants, as well as my role in the research, to inform my decision to select an appropriate approach to guide the research process.

3.3   A Social Constructionist Epistemological Stance

I have approached this research from a social constructionist epistemological stance. The reason for this was informed by the primary research focus which was mainly concerned with the nature and acquisition of knowledge and how people come to know their realities and identities, rather than the nature of reality and being (ontological assumptions). Drawing from the works of Edley (2001) and Edwards (1997), Burr (2003) explained the different senses in which social constructionism can be used, namely ontological and epistemic. The epistemic sense rests on the idea that we construct particular accounts of what the world is like when we think and talk about the world. The ontological sense of social constructionism makes reference to the manner in which reality is constructed and brought into existence in all the particular forms as a result of shared language use (Burr, 2003).

Due to the particular research focus, the nature of reality (ontological assumptions) was mainly bracketed for the purpose of this research as it was not of primary concern (Burr, 2003). However, without the liberty of complete ontological freedom, it is worthy to note that I have adopted a relativist ontology to inform the epistemological stance (Burr, 2003;

Raskin, 2002). This encompassed the acceptance of multiple versions of reality as being

equally valid, allowing for each participant's story to contribute to the shared co-construction

of the meaning making process which informed the research question: What meaning did the

group members attribute to the support group?

Next, I outline the main social constructionist assumptions which motivated my

choice for adopting this stance. The next section will also cover some of the primary

assumptions and concepts which informed the construction of this research report.

3.4   Social Constructionism: An Appropriate Approach

Social constructionism accepts multiple versions of reality as equally valid accounts

of truth. It offers an alternative way to study humans as social beings in contrast to the

objective empiricist assumptions of the scientific method (Burr, 2003; Du Preez & Eskell-

Blokland, 2012). Situated in the postmodern worldview, social constructionism is considered

a critical approach as it challenges the notion of objective empirical knowledge claims (Burr,

2003; Gergen, 1985). Social constructionism asserts that we come to know the world through

our interpretations of it and thus, there can be multiple accounts of "truth" each valid in its

own right (Burr, 2003; Du Preez & Eskell-Blokland, 2012). This approach thus allowed each

participant to share their subjective accounts of the group's meaning as valid reflections of

their experiences and to be incorporated into a shared meaning.

The social constructionist approach further asserts that researchers are subjectively

involved in the work they investigate or explore rather than being objective and detached

from the process of enquiry. The meaning the researcher attaches to the situation under study

is considered an important part of the research process (Burr, 2003; Du Preez & Eskell-

Blokland, 2012; Jordaan, 2010). This notion allowed for my involvement in the meaning

making process and afforded value to my extensive relationship with the participants and my familiarity with the context. This approach thus welcomed my dual roles as group facilitator and researcher by placing me in a central position in the research process without my previous involvement with the participants being problematic. This strongly encouraged my choice for adopting this approach. The primary assumptions of social constructionism also resonated with the research aim, which further supported my choice for selecting this approach.

3.4.1   The main assumptions informing the research.

The main social constructionist assumptions that informed this research were 1) the co-construction of meaning, 2) the role of language in the construction of lived experiences, 3) social relations as the context of meaning making, 4) the fluidity of identity, and 5) the influence of power (in its various forms and manifestation) on meaning making and people's construction of their realities. Each of these assumptions are now unpacked to demonstrate their relevance to the research.

3.4.1.1 The co-construction of meaning.

Social constructionism is concerned with the co-construction of meaning (Burr, 2003; Gergen, 1985). This approach asserts that meaning is created between people in their daily relations and social interactions in social contexts. Social constructionism places an emphasis on how meaning is created in conversation with others (external social processes) rather than emerging from within the individual's own point of view (internal personal processes) (Hoffman, 1990; Jordaan, 2010; Shotter, 1997). It was thus suitable to explore the meaning created between the group members within the social context of the support group.

3.4.1.2 The role of language in the construction of lived experiences.

The constructive force of language and other symbolic forms is at the heart of social constructionist research (Burr, 2003; Du Preez & Eskell-Blokland, 2012). Social constructionism asserts that people co-create meaning by drawing from language and the symbolic meanings connected to knowledge (Burr, 2003; Gergen, 1985; Jordaan, 2010). The influences of societal discourses and personal narratives are thus instrumental in the meaning making process.

This approach thus allowed for ways of understanding the constructive forces behind the research participants' construction of their group experiences and the meaning it had for them. During my prolonged involvement with the group, I obtained a reasonably well informed understanding of how language and societal discourses influenced the way the group members viewed themselves as individuals living with chronic and severe mental illnesses in their local community. Social constructionism allowed for the illumination of these influences on the meaning making process.

3.4.1.3 Social relations as the context for meaning making.

Social constructionism infers that people construct meaning in social interactions with others rather than obtaining it from the natural world as implied by positivism (Du Preez & Eskell-Blokland, 2012). It can be said that the social realm is the context in which meaning making occurs. Cultural influences and societal beliefs heavily influence the dominant societal discourses and stereotypes and play a significant role in meaning making and the ways individuals view themselves and make sense of their life worlds (Shotter, 1997). Meaning making is thus historically and culturally relevant (Burr, 2003; Raskin, 2002; Shotter, 1997).

As discussed in the literature review, the dominant societal discourse of mental illness is still predominantly negative. There is a societal belief that people with mental illness are unpredictable and dangerous. As a result, most people do not want anything to do with those who suffer from mental illness which contributes to the isolation and alienation of many MHC users (Jones, 2009; Nsereko et. al., 2011; Simpson & Sambuko, 2011). The group setting provided an alternative social context for the group members where they could share their experiences of daily living as individuals with mental illness. Within the group, the group members were afforded the opportunity to challenge the negative societal discourses regarding mental illness and renegotiate alternative social identities.

3.4.1.4 The fluidity of identity.

From a social constructionist perspective, individual identity is considered to be fluid. This infers that individuals possess the ability to redefine their identities when they find themselves in a context where they can engage in dialogues with others which challenge generally accepted beliefs and assumptions (Raskin, 2002; Shotter, 1997). Bakhtin said:

> Truth is not to be found inside the head of an individual person, it is born between people collectively searching for truth, in the process of their dialogic interaction (Shotter, 1997, p.3).

By sharing their experiences of discrimination, stigmatisation, and isolation, the group members were allowed an opportunity to understand their experiences and negotiate new identities for themselves. The members could identify with each other and establish a sense of belonging within a society from which they are, and felt excluded. The group members could then renegotiate their identities and form new understandings and meanings of their experiences of stigmatisation and isolation within the group setting.

3.4.1.5 The influences of power on the meaning making process.

From a social constructionist standpoint, the influences of power are considered to be instrumental in the meaning making process and thus of interest to social constructionist researchers (Burr, 2003). Social constructionists believe that our ways of understanding phenomena influence the way we see ourselves and the manner in which we treat people and situations. For example, the medieval belief that mental illness was caused by witchcraft and demon possession resulted in many being burnt at the stake. Our beliefs are heavily influenced by the dominant societal discourses. This intricate relationship between knowledge and actions is considered to be one of power (Burr, 2003). Psychological and psychiatric concepts of normality and abnormality, sanity and insanity have powerful influences in societal discourses; this was highlighted in the conversations of the group members.

The experiences of the group members, as individuals living with mental illness, were influenced by the dominant societal views of mental illness. The group provided a context in which the group members could challenge these discourses and shift the power in their favour as they challenged the dominant discourses while negotiating new identities within the context of the group.

These five social constructionist assumptions guided the analytic process. It was against the backdrop of these assumptions that I have made sense of the participants' stories. The influence of language and societal discourses and its power on the meaning making process were interpreted and informed by a social constructionist viewpoint.

3.5   The Research Method

3.5.1   A qualitative approach.

The research approach refers to all the decisions a researcher makes in planning the study (Fouché, 2005). Similar to choosing the most appropriate epistemology for the research endeavour, Willig (2008) explained that there is no "right" or "wrong" when choosing a research approach, but rather that the researcher should choose an approach that is most appropriate to answer the research question. The research question was thus instrumental in guiding the particular epistemology and approach taken to conduct the research. This research set out to explore and describe the shared meaning that the group members created of the support group as well as their group experiences. Due to the explorative nature of the research question, I chose a qualitative approach to drive the research endeavour.

Qualitative research is concerned with meaning making and allows for rich descriptive accounts from the participants' subjective perspectives (Denzin & Lincoln, 2011; Willig, 2008). I utilised a set of qualitative data gathering techniques in order to elicit rich descriptions from the participants' subjective accounts of their group experiences and the meaning that the group had for them. The techniques used to collect the data entailed semi-structured interviews and a collage-making and storytelling technique. These techniques are discussed in greater detail later in this chapter.

As mentioned earlier, the researcher's epistemological stance also informs the selection of an appropriate research approach and the two should therefore be congruent (Willig, 2008). Both social constructionism and qualitative research are concerned with the role of language and meaning making and so a qualitative approach fitted coherently with the

social constructionist epistemology. The rich descriptive data obtained through the data

collection methods of qualitative research made it possible to illuminate the meaning that the

group had for the participants by allowing them freedom to express themselves from their

subjective points of view and thus allowing the participants to have their voices heard (Stein

& Mankowski, 2004). Furthermore, gathering qualitative data rendered an open-ended,

inductive exploration of the group's meaning possible and was suitable to explore this

underexplored research topic (Ponterotto, 2005; Terre Blanche, Kelly, & Durrheim, 2008).

Denzin and Lincoln (2011) explained how qualitative research is a multi-method in

focus as it uses triangulation of multiple data sets in an attempt to obtain an in-depth

understanding of the phenomena under study. To achieve triangulation, the data were

collected in two consecutive phases and combined in the analysis process.

3.5.2   A generic design.

Qualitative research approaches are fluid in nature, allowing the researcher to create a

design best suited for the research at hand by drawing from a range of qualitative research

strategies or tools (Fouché, 2005). The purpose of the study, the nature of the research

question, the guiding epistemology, the researcher's placement in the research process, and

the skills and resources available to the researcher are what ultimately guide the research

strategy of choice (Fouché, 2005; Probert, 2006).

With this in mind, I consulted various sources in search of an appropriate qualitative

research design (Cooper & Endacott, 2007; Denzin & Lincoln, 2011; Probert, 2006; Willig,

2008). After careful consideration, I chose a generic design as none of the existing

established qualitative designs satisfactorily fitted with the vision I had in mind for this

research endeavour (Probert, 2006). I was not satisfactorily convinced that the research could

fully meet the requirements for any one of the established qualitative designs, for example multiple case study or ethnography, and was thus motivated to opt for a generic design which afforded me the flexibility to construct the most appropriate design for this particular research endeavour.

A generic design does not conform to any of the established qualitative research approaches, but is rather selected for practical reasons (Caelli, Ray, & Mill, 2003). The generic design seeks to explore, discover, and understand a specific process and perspectives or worldviews of research participants through adopting different methods to gather and analyse the research data (Caelli et al., 2003; Cooper & Endacott, 2007). The researcher should, however, ensure that the different methods selected for collecting and analysing the data are congruent with one another as well as the guiding epistemology.

Johnson, Long, and White (2001) proclaimed that the rigid adherence to any one of the established qualitative research approaches is in many cases neither necessary nor likely to increase the validity of the research outcome. Cooper and Endacott (2007) similarly asserted that the distinguishing features of the established approaches limit their applicability to studies which do not seek to investigate a topic exactly as required by any of these established approaches. Johnson et al. (2001) further proclaimed that all published qualitative methods are subject to their own underlying relativist philosophy with the implication that they are all social constructions and that their execution is consequently negotiated in time and context. The generic design thus allowed me flexibility to construct a design which resonated best with the research purpose and process, drawing from my insider perspective and personal motives to conduct the research in a manner that brought about trusted outcomes with which to make a worthwhile contribution to the field of MHC research.

When adopting a generic research design, it is important to clearly describe the methods adopted to collect and analyse the data, the analytic lens through which the data were examined, as well as the strategies to establish rigour. This is required to create a convincing, credible account which would be valued in the scholarly community (Caelli et al., 2003; Cooper & Endacott, 2007).

3.5.3   The research participants.

The research participants included the core group members of the MHC social support group at the TDCHC. The participants were selected by means of purposive sampling. This process entailed selecting participants on the basis of the study's purpose and the knowledge and elements of the research population (Babbie, 2013). In this case, the participants included the core group members who could share their stories of their group experiences and the meaning the group had for them.

The research participants were selected on the basis of the following inclusion criteria: they must have 1) been a member of the group for at least one year; and 2) asymptomatic at the time of the data collection as affirmed by the MHC psychiatric nurse with whom they had a long standing relationship. This was necessary to ensure that the participants were well and fully capable of providing their informed consent and able to participate in the research activities. Because MHC users are considered a vulnerable population, it was important to have confirmation from a qualified MHC professional that the participants were asymptomatic at the time of data collection.

The research participants were heterogeneous with regards to their ages and diagnoses. A total of five participants participated in the study: four males, one female all of African origin. Their ages ranged from 23 to 60 years. All the participants suffered from

severe mental illness including Schizophrenia and Bipolar Mood Disorder with psychotic features.

3.6   Methods of Data Collection

De Vos (2005) asserted that qualitative research relies on the presentation of descriptive data with which the researcher leads the reader to an understanding of the meaning of the experience or phenomenon under study. I therefore pursued methods which would elicit rich descriptive accounts of the participants' experiences of the support group that would lead me to a deeper understanding of the meaning they attributed to the group. The data sets were collected in two consecutive phases. Phase one entailed individual semi-structured interviews followed by phase two which utilised an adaptation of a collage making tool known as the Collage Life-story Elicitation Technique. Each of the data collection phases and the motivations for selecting these methods are now discussed.

3.6.1   Phase one: Semi-structured interviews.

Initially, semi-structured interviews were conducted with the participants to obtain their biographical information and as well as information on their background and their involvement with the group. Prior to each interview, I obtained written informed consent from the participants after receiving affirmation from the MHC psychiatric nurse that the participants were asymptomatic at the time of the interviews and able to provide their consent.

Semi-structured interviews allowed me to direct the conversations and to obtain in-depth information from the research participants while allowing them freedom to express themselves (Creswell, 2014). I probed when clarity was required or when I needed the

participants to provide further detail (Fouché, 2005). These interviews also allowed the participants to share their stories, aiding the co-constructive meaning-making process between us which allowed me to gain a detailed picture of their personal accounts of the meaning they attached to the group (Fouché, 2005).

The interviews were conducted with the assistance of a translator. Using a translator afforded the participants the opportunity to express their thoughts and feelings in the language they felt most comfortable with and it ensured that the participants understood what was asked. The participants' permission was obtained to audio record the conversations for translation and analysis purposes.

The themes of the interview schedule (Appendix 4) elicited information on the history of the participants' mental illness and the treatment they had received. It also covered the participants' history with the group, their reasons for joining, benefits obtained from being in the group, and some of their group experiences.

3.6.2   Phase two: Collage making and storytelling.

For the second phase of the data collection process, I utilised an adaptation of a narrative story-telling technique known as the Collage Life-story Elicitation Technique, also known as the CLET (Van Schalkwyk, 2013). The CLET has its roots in social constructionism, narrative psychology, and symbolic interactionism. It can be used as a tool for collecting qualitative data which is both verbal and non-verbal in nature. The CLET enables the researcher to elicit life-stories with the help of collage making. The aim is to provide the researcher with a better understanding of how individuals experience relationships or attachments, and how certain societal customs, attitudes, and interactions influence the perceptions and experiences of these individuals (Van Schalkwyk, 2013). It

also assists with the recollection of memories. The specific instructions provide a

"scaffolding" which helps participants to structure their memories in their unique ways. The

collage making activity allows the participants time to think about their experiences as they

create and re-construct their memories.

After obtaining written informed consent from the participants and confirmation from

the local MHC psychiatric nurse that all the participants were asymptomatic and able to

participate in the activities, I introduced the structure for the day which started with the

collage making activity. The participants were instructed on how to make their collages.

They were asked to make a collage about the group using eight to ten pictures, cuttings (text

as well), trying to answer the question, "How does each picture/image/drawing represent

something important or memorable about the group in my life?" The participants were free to

paste the images in any way they wanted on the A3 sheets of cardboard that were provided.

The collage making activity took place in a group setting, but each participant worked on and

created an individual collage.

After completing their collages, each participant was asked to tell the stories of the

pictures on their collages in order to reveal the meaning they ascribed to the group and their

group experiences (Van Schalkwyk, 2013). They were asked why they chose the particular

pictures, what each picture represented, and what made each picture important to them as a

representation of the group. This step took the form of a collaborative individual semi-

structured interview and was not conducted in a group setting. These interviews were

directed by the participants themselves as they told their stories with reference to their

collages (Van Schalkwyk, 2013). Probing techniques were used when and where additional

information was required and the translator assisted as needed. I encouraged the participants

to communicate in the language they were most comfortable with. The translator translated

the feedback of the participants as well as my comments and probing questions. This was undertaken in an effort to increase the study's credibility (Gravetter & Forzano, 2009; Denzin & Lincoln, 2011).

A strong motivation to use this technique as a data collection tool was that it allowed the participants to lead the interview. The participant-led storytelling brought about unique and authentic stories as constructed by the participants themselves. This limited the extent to which my predetermined subjective interpretations of the participants' experiences could influence and possibly bias the recollection of their group experience memories and the meaning they ascribed to the group. The conversations were again audio-recorded with the permission of the participants.

3.7   Data Analysis

The data collection methods generated two different data sets for each participant. These consisted of the phase one and phase two interview transcripts. The collages merely served as references for the phase two semi-structured interviews and were therefore not analysed as a stand-alone data set. I conducted a thematic analysis on the phase one and two interview transcripts and triangulated the findings from the different data sets to construct the themes and sub-themes which represented the meaning the group had for the participants. Triangulation entails the combination of multiple data sources in a single study with the aim of adding rigour, breadth, complexity, richness, and depth to inquiry (Denzin & Lincoln, 2011). Gathering research data using multiple methods strengthens the study's usefulness and enhances the study's transferability to other context specific situations (De Vos, 2005).

Thematic analysis is a qualitative data analysis method which enabled me to provide rich, detailed, and complex accounts of the research data in a sensible manner (Braun &

Clark, 2006; Fereday & Muir-Cochrane, 2006). According to Braun and Clark (2006),

thematic analysis is compatible with the constructionist paradigms as it is not bound to one

specific theoretical approach and it was thus compatible with the research design of this

study.

The aim of thematic analysis is to systematically work through the different data sets

with the research question in mind by identifying patterns in the data sets (Braun & Clark,

2006; Fereday & Muir-Cochrane, 2006). I followed the six phases of thematic analysis as

outlined by Braun and Clark (2006):

1. Familiarising myself with the research data: This entailed reading and re-reading

   the interview transcripts several times in order to get a feel for the data in its

   totality while noting initial ideas and key concepts as they occurred to me (De

   Vos, 2005).

2. Generating initial codes: This step required me to systematically code interesting

   features across the data sets which I felt captured the meaning the group had for

   the participants, and collecting all the data relevant to each individual code.

3. Searching for themes: Next, I reviewed all the quotations of the identified codes

   and grouped the codes into potential themes. I strived to create themes which

   consisted of coherent data which made each theme uniquely distinguishable

   (Braun & Clark, 2006; Fereday & Muir-Cochrane, 2006).

4. Reviewing themes: I confirmed whether the data within the themes coherently

   fitted together by revising all the extracts and ensuring that each accurately

   reflected the overarching theme. The themes were revised as required.

5. Defining and naming themes: I provided names and definitions of the themes to

   demonstrate what each theme entails.

6. Producing the report: Extracts were selected to provide examples of what

constitutes the themes. (Braun & Clark, 2006; Fereday & Muir-Cochrane, 2006).

A co-coder assisted with the analysis process in order to increase the trustworthiness

of the findings.

3.8   Measures of Trustworthiness

"Measures to ensure trustworthiness" refers to a set of criteria against which to

evaluate the soundness of one's research and help the reader establish the truth value of the

findings (Creswell, 2015; De Vos, 2005). The following measures of trustworthiness were

put in place to ensure the rigour with which I drew my conclusions (Tobin & Begly, 2004):

credibility; dependability; confirmability; transferability; triangulation; and reflexivity.

In order to guarantee the *credibility* of the findings I had to ensure that the research

participants were accurately identified and described by thoroughly outlining the study's

parameters (the research setting, study population, and the guiding epistemology) in order to

place the boundaries around the study (De Vos, 2005). To ensure the credibility of the data

collection, I employed a translator to give the participants the choice to express themselves in

the language they felt most comfortable with and to ensure they understood what was asked

of them. To ensure credibility of data analysis, I asked an independent co-coder to conduct a

separate thematic analysis on the data sets and compared the main themes drawn from the

data in order to check for consistency of the emerging themes.

Dependability entails meticulously documenting the decisions I have made, and the

processes that I have undertaken during the research endeavour. I attempted this through

leaving an audit trail of the collected data, the interview transcripts, the coding procedures, as

well as the analysed data. This allowed for the readers to assess the study's dependability. In addition, this allowed for *confirmability* of the findings as it could be verified and confirmed by others.

The outcomes of qualitative research approaches are usually drawn from smaller sample sizes and are therefore not suitable for generalisation to people other than those under study (Creswell, 2014; Stein & Mankowski, 2004). Transferability of the findings to other context specific situations is the qualitative equivalent of generalisability (De Vos, 2005; Tobin & Begly, 2004). In order for others to determine whether the research findings could be applicable to other context specific settings, I documented the study parameters and processes in detail. This allowed for those who conduct policy or design research studies within the same parameters to be able to determine whether or not the cases described in this study can be generalised for new research policy and transferred to other settings (De Vos, 2005).

The generic qualitative research design requires the researcher to obtain data from multiple methods and independent sources (Cooper & Endacott, 2007; Denzil & Lincoln, 2011). The different data sources consisted of the interview transcripts drawn from the two phases. Triangulation of data from multiple sources is an alternative to validation in qualitative research (Cooper & Endacott, 2007; Denzil & Lincoln, 2011). This is a means for the researcher to establish rigour with which to enhance the reliability and validity of the research data (Creswell, 2014; Denzin & Lincoln, 2011).

Furthermore, I declared my position in the research as well as my role as researcher and the possible implications thereof on the outcomes of the research in reflexive accounts throughout the research report. This required me to continuously reflect on my influence in

the research decisions and processes as well as the final interpretations and conclusions, and for the reader to determine the credibility of the findings (Shenton, 2004).

3.9   Ethical Considerations

Ethical clearance was obtained from the Department of Psychology's Research Ethics Committee at the University of South Africa (Appendix 1). Institutional approval and permission to conduct the research was also obtained from The Department of Health (Appendix 2), the Head of the TDCHC, and the MHC practitioners in the centre's Mental Health division.

All the participants gave written informed consent after receiving a clear, detailed explanation of what was required of them, as well as the aim and purpose of the research in a language that was understandable to them with the assistance of a translator. I explained that their participation in the research was completely voluntary and if they chose not to participate there would be no negative consequences (Babbie, 2013). It was made clear that they could withdraw from the research at any given time (Gravetter & Forzano, 2009). The participants were afforded an opportunity to ask questions about anything that they were unsure of.

To ensure that the participants were able to give full informed consent, the MHC psychiatric nurse, who had a longstanding relationship with the participants, confirmed whether they were all asymptomatic at the time of data collection. She also confirmed whether they understood what was required of them and whether they were willing to participate.

To ensure that I conducted ethical research, I took caution to conduct the research within the boundaries of my current research capabilities and competence (Gravetter & Forzano, 2009). All the data collected during the course of the research were treated with care and confidentiality.

I treated the participating group members with respect and dignity at all times to ensure that no physical or psychological harm was done to them during the course of the research (Babbie, 2013; Gravetter & Forzano, 2009).

At the conclusion of the research, I held a debriefing session with the participating group members during which they were informed of the outcome of the research. This also allowed them an opportunity to reflect on their experiences of participating in the research process and to share how they thought the experience contributed to their personal growth and to comment on the findings (Creswell, 2014; Denzin & Lincoln, 2011; Van Schalkwyk, 2013).

3.10   Chapter Summary

This chapter outlined the guiding epistemology which informed the research process. It also described the method to conduct the research and analyse the data. Furthermore, I explained the measures adopted to enhance the trustworthiness of the results and the ethical considerations.

Chapter 4

Co-created Meaning: A Discussion of the Main Themes and Sub-themes

4.1   Chapter Overview

The analysis of this research set out to explore what meaning the participants attached to their group membership. The meaning reflected in this chapter consists of a co-construction which was generated between myself and the participants, and verified by an independent co-coder. The chapter furnishes a description of the data preparation steps, analysis, and meaning making processes. It also outlines a description of the group members who participated in the research. The main themes and sub-themes that emerged from the co-created meaning making process are presented and discussed in the light of existing literature.

4.2   Data Preparation and Analysis Processes

4.2.1   Data preparation.

The interview recordings were transcribed directly into English with the assistance of two research assistants from the study area. Direct English translations were opted for to save time and limit research expenses. The assistants checked each other's translated transcripts against the original audio recordings for accuracy. Any discrepancies were highlighted and the suggested translations were indicated.

The discrepancies were subsequently addressed with the assistance of the on-site translator. The audio recordings were checked and the translator indicated the most accurate translations. These measures were followed to guarantee that the transcripts used in the analysis reflected the most accurate versions of the original content and to ensure that the analysis was based on reliable data sets (Kanjee & Foxcroft, 2009).

Despite these efforts, it is likely that some of the meaning of the participants' data was lost in translation. Ideally the transcripts should have been transcribed verbatim, coded, and categorised into themes from the verbatim transcripts and then translated. However, every effort was made to ensure that the translation was as close to the original data as possible.

4.2.2   The analysis process.

The checked transcripts were thematically analysed according to Braun and Clark's (2006) six phases discussed in chapter three. I used Atlas.ti© version 6.1 software to code the data. After coding both the phase one and two data sets, outputs for all codes and quotations were generated. The outputs were reviewed to ensure that all the quotations adequately reflected the assigned code labels out of context of the full transcripts. I reassigned a number of quotations to different code labels and made the adjustments in Atlas.ti©. Another set of outputs were generated following the initial adjustments and I repeated the process making further adjustments. The third set of outputs was used in the initial analysis process.

A co-coder conducted an independent analysis also following the phases of Braun and Clark (2006). After analysing the data sets independently, we discussed the results with a view to reaching consensus and constructed an alternative set of themes together. This comprised the second analysis process. Codes and quotations were further adjusted and altered to ensure that we both agreed that the quotations adequately reflected the assigned code labels. The necessary adjustments were made in Atlas.ti© and another set of outputs was generated, which was used to construct the final set of themes and sub-themes reflected below, representing the third and final analysis process.

4.3   Co-created Meaning

Social Constructionism holds that meaning is co-created between people in social interactions. Furthermore, meaning that emerges from social interactions is influenced by societal discourses as well as personal and collective experiences of the agents involved in the meaning making process (Burr, 2003; Gergen, 1985). The meaning that emerged from this research endeavour was thus a co-created process. On the one hand, I reflected the group's meaning based on my personal experiences with the participants. On the other hand, the participants' individual experiences from the perspective of living with mental illness in a society with a predominantly negative attitude towards mental illness, as well as the collective group experiences, also contributed to the group's meaning reflected in this report.

The themes and sub-themes presented in this chapter are but one of many possible constructions. Meaning making from a social constructionist viewpoint is subjective and accords equal value to various versions of experience. In my effort to reach a reliable reflection of the group's meaning and ensure credibility of the analysis, I consulted the input and opinion of an independent co-coder. During the analysis process I perceived various possibilities of constructing meaning. By obtaining input from the co-coder I could verify whether the themes constructed from my point of view made sense from another perspective. The co-coder was not involved with the group processes or the research participants and could thus confirm whether the data reflected the constructed realities from the analysis processes.

A short description of the research participants is provided next to introduce some background on the agents who participated in the meaning making process.

4.4   The Research Participants

A total of five group members participated in both phases of the data collection interviews. At the time of the data collection, which took place in May and June 2014, all the participants had been with the group for at least one year. They all stemmed from a lower socio-economic status, were unemployed, and received disability grants. Each of the participants are now introduced in greater detail.

4.4.1   Participant 1.

Participant 1 was a 29 year old Ndebele male. At the time of the data collection, he was busy completing his Level four education. He had never been formally employed but in the past, he has held volunteer jobs in the local community. When asked about his diagnosis, he mentioned that he was sometimes told that he suffered from Bipolar Mood Disorder and sometimes from Schizophrenia. He said that he felt confused about his diagnosis as it changed from time to time. When I asked him what *he* thought about his diagnosis, he said that he felt fine.

He experienced his first symptoms in 2005 at the age of 20 when he was admitted to the local community hospital. He mentioned injections and oral medication as the primary forms of treatments received. He also sought treatment from an occupational therapist and a social worker. He had been with the previous support group at the TDCHC which had terminated. He joined this group in 2010, a few months after its initiation. Participant 1 was introduced to the group through the occupational therapists at the TDCHC after asking her to introduce him. He had seen the group meetings taking place when he visited the centre for his follow-up appointments with the psychiatric nurses and wanted to become a part of the group too.

4.4.2   Participant 2.

Participant 2 was a 57 year old Northern Sotho male. He completed Grade nine and was retrenched from his job in 2007 at the age 50 when he was first diagnosed with Bipolar Mood Disorder. Participant 2 mentioned that he had been to Weskoppies Psychiatric Hospital in the past and mentioned receiving only psycho-pharmacological treatment for his condition.

Participant 2 had been with the group since the first group meeting and regularly attended the group sessions. He received an invitation to join the group from the psychiatric nurse at the TDCHC. Since joining the group he had not experienced a significant relapse until approximately one year after the data collection.

4.4.3   Participant 3.

Participant 3 was a 31 year old Pedi male with a Grade nine education and no previous employment history. He recalled first becoming ill approximately 10 years ago in 2004. When asked about his diagnosis he did not mention a specific disorder but explained that he was told he became ill as a result of his substance use. He mentioned that he had been admitted to Weskoppies Psychiatric Hospital on various occasions prior to joining the group. He said that he had mainly received psychiatric treatments such as oral medication and injections, but had also sought help from social workers at a local non-government organisation where he was taught about the effects of substance use on the brain.

Participant 3 also received the initial invitation to join the support group and had been with the group since its initiation. Since 2010, he has not returned to Weskoppies Hospital, but was admitted to the local community hospital following a suicide attempt.

4.4.4   Participant 4.

Participant 4 was a 60 year old Pedi woman. She completed Standard four and also stopped working because of her mental illness. She recalled first becoming ill in 1968 and mentioned previous admissions to Weskoppies Psychiatric Hospital. She indicated that she had received medical treatments as well as help from the psychologist at the TDCHC and social workers within the local community.

I recall her being present at the very first group meeting after which she did not return for a couple of months. On her return to the group her behaviour was disruptive and the psychologist removed her from the group setting for individual therapy. She re-joined the group after a few individual sessions and showed drastic improvements in her social interaction within the group context. She has experienced multiple relapses since 2010. Despite her occasional, sudden, and unexpected relapses, she regularly attended the group meetings and always mentioned how she enjoyed being with the group. Participant 4 has displayed significant improvements in her social interaction within the group. She also mentioned how the group helped her to enjoy better social relationships with other people in her life.

4.4.5   Participant 5.

Participant 5 was a 23 year old Pedi male. He completed Standard four and enrolled for Adult Based Education and Training in 2008. He did not mention any previous work experience. He recalled becoming ill when he was 12 years old and has received psychiatric treatment ever since he was a child. He only said that he suffered from mental illness and that he was taking medication for his condition. During the group sessions and the data collection interview he spoke about hallucinations, indicating that he experienced psychotic

symptoms. He often shared his experiences of being stigmatised because of his mental

illness.

Participant 5 joined the group in 2013, about one and a half years prior to the data

collection interviews. He was referred by the psychologist at the TDCHC. He also said that

he once spoke to a social worker about his problems and asked for assistance to find a school

and employment. He said that he was referred to the group for help and that the group had

been a great source of support in his life.

All the participants reported past experiences of psychotic symptoms. They all lived

with severe and chronic mental illness for a substantial period. Before joining the group, all

the participants were unemployed and engaged in few social activities. The following section

represents the co-constructed meaning of the support group.

4.5   The Meaning the Participants Ascribed to the Group

This section represents the meaning the research participants ascribed to the group.

The following table outlines the main themes that were constructed from the analysis. The

sub-themes represent the content that comprises each theme.

Table 4.1
Main themes and sub-themes

Main theme	Sub-themes
Theme 1: **Social rejection versus social connectedness and belonging**	Social rejection: Stigmatisation and social isolation
	Social connectedness and belonging: Socialisation, friendship, and a sense of belonging
Theme 2: **Mobilisation and stimulation**	Group project and outing: Offered structured opportunity for responsibility, ownership, and reward
	Group activities: Tools for physical and mental stimulation
Theme 3: **A source of support**	The role of medical and financial support in the maintenance of mental illness
Theme 4: **The learning experience**	Social and emotional support provided by the group Psycho-education
	Interpersonal learning
	- Sharing stories and personal experiences
	Rehabilitation
	- Interpersonal skills: communication, listening, conflict management
Theme 5: **Transformation and growth**	Societal discourses and self-stigmatisation
	Lost dreams and limitation caused by mental illness
	Desire for normalisation and identification with social norms
	Hopefulness for the future

4.5.1   Theme 1: Social rejection versus social connectedness and belonging.

The first theme illustrates the social connectedness and sense of belonging that the

group offered the participants in contrast to the social rejection and isolation they experienced

within their community. The participants reported feeling happy in the group when they

were together. All the participants shared stories of past experiences of stigmatisation or

social isolation. When asking the participants during their phase one interview why they

joined the support group, Participant 3 described that his reason for joining the group was motivated by his boredom and lack of social productivity which was a consequence of his social isolation. The following extraction between the translator (T) and Participant 3 (P3) illustrates this:

> P3: *I saw that I was doing nothing at home so I saw it was better I join the group. Even now, there is nothing I am doing at home. All I do is sleep, maybe sometimes I do some gardening at home…*
>
> T: *What else has made you come to the group?*
>
> P3: *It's because I just sit at home. I see there is no point in just staying doing nothing at home* [sic].

Participant 3's extract illuminates his low level of social productivity and isolation which was also found amongst participants diagnosed with Schizophrenia in a naturalistic ten-year follow-up study by Shrivastava et al. (2011). Despite attending the group for four years, it did not assist Participant 3 to increase his social interactions and community participation much. He mentioned that he is still socially inactive. This indicates a need for community-based interventions which are focused on mobilising isolated MHC users like Participant 3 to become active community participants. Section 8(1) in the MHCA (2002) specifically advocates the right of MHC users to receive treatment, care and rehabilitative services to help them reach their full potential within their respective communities. Addressing the need for additional resources to assist MHC users like Participant 3 reach their full human potential is thus in accordance with the MHCA (2002) as well as the recovery model approach advocated in the National Mental Health Policy Framework and Strategic Plan 2013-2020 (South African Department of Health, 2012). Participant 3's

expression of social inactivity is an indication that such services are possibly lacking in this particular community and that this service need requires further exploration and attention.

Furthermore, literature highlights that MHC users living with severe and chronic mental illness are often stigmatised and alienated from society and that the social rejection and stigmatisations are more painful than the disorder (Drake & Whitley, 2014; Fleury et al., 2013a). Although not all the participants shared equal extents of social isolation, each of them reported past incidents of stigmatisation or losing touch with friends as a result of their mental illness. It appeared that some of the participants could maintain some level of social activity after being diagnosed. Participant 1 often reported being out visiting family and attending college classes. Participant 4 was very involved with her church and often spoke about attending services over the weekends. Fleury et al. (2013a) analysed factors associated with the needs of people with severe mental disorders and found religion to be an important source of socialisation and emotional support. Participant 4's strong connection to her church could thus be interpreted as her need for socialisation and sense of belonging. She often shared how much she loved going to church and expressed the enjoyment she received from her religious membership. The varied degrees of participation in social activities expressed among the participants highlight their varied levels of social functioning and the importance of addressing the unique needs of MHC users.

The first sub-theme illustrates the extent to which the participants felt socially excluded from their community whereas the second sub-theme illustrates the extent to which the participants felt socially included within the context of the group. These sub-themes are unpacked next.

4.5.1.1 Social rejection: Stigmatisation and social isolation.

This sub-theme illuminates the participants' experiences of stigmatisation and social isolation. All the participants have had experiences of being stigmatised as a result of their mental illness at some point. Participant 5 particularly highlighted his experiences of stigmatisation during the data collection interviews. The following extracts provided by Participant 5 thus represent the stigmatisation experienced by the participants as a result of their mental illness. During his first interview he said:

> P5: …*I had a problem of being laughed at by people saying I'm sick. At other times maybe laughing at my clothes as to how I'm dressed… I couldn't understand what they were laughing at and sometimes be* [sic] *troubled by people…*

During his second interview, he described how experiences of stigmatisation were also true for his fellow group members and others living with mental illness:

> P5: …*just like us, people who are mentally sick mostly, there are challenges that we meet, people teasing us and others abusing us… the mentally ill, in most cases have challenges—laughed at by other people, people making fun of us…*

MHC users, such as the participants, suffering from severe conditions accompanied with psychotic features are more prone to stigmatisation and alienation because their symptoms are more evident and their behaviour is sometimes odd. Drake and Whitley (2014) pointed out that stigmatisation and victimisation of people with mental illness are barriers to the recovery process which hinder their community integration and social connectedness.

What follows are additional illustrations of social isolation provided by the participants during the phase one interviews. Participant 1 explained his sadness and sense of loss he felt just before joining the group in 2010. He explained how he lost touch with his friendship group at school when he first became ill:

> P1: *...at that time (before joining the group) I felt like I lost touch with them.*
>
> I: *With whom?*
>
> P1: *The-the-the previously* [sic] *group, the small group…*

Participant 1 said that he wanted to join the support group to be with others just as he was once part of a group when he was at school before he became ill. This illustrated his longing for social connection (Drake & Whitley, 2014).

Many people in society accept the negative stereotypical notions of people with mental illness as portrayed by the media and as a result do not want anything to do with people suffering from mental illness as they are perceived to be dangerous and incapable of communicating (Arboleda-Flórez & Stuart, 2012; Stuart, 2003). I felt the following extract by Participant 5 during his first interview illustrated this:

> P5: *…and again outside here I'm unable to communicate with others because others say we don't want to speak to this one, he is sick. So when I greet them they just keep quite. Sometimes when I try to communicate with people they don't want me, so this way when I'm in the group I feel alright because I can communicate in the group…*

Participant 5 described how the support group offered him a sense of belonging as it was a place where he could communicate with others. He explained how people in the

community sometimes ignored him because of his mental illness. This extract by Participant 5 supports research highlighted by Drake and Whitley (2014) which noted that people with severe mental illness greatly valued being known, understood, and accepted.

The following phase one dialogue extract between me (I) and Participant 3 (P3) further illuminates the social isolation experienced in the community and how the group offered him a sense of social inclusion and belonging:

I: *...how is your life different since you've been part of the group?*

P3: *Eish. Ah, before... I was not doing anything at home, just sitting alone. Maybe looking for the car, maybe sometimes I* [sic] *trying to join my friend, ah my friend go* [sic] *with me but doesn't go with me very long, say ah—say maybe I see him* [sic] *next time... I don't do anything at home. I wake up just…* [pause] *maybe sometimes I wash, sometimes I not—don't wash, but—ah maybe I-I'm stand—maybe I'm standing with some girl, my neighbour.*

I: *...when you don't come to the group who do you speak to?*

P3: *No one...*

Social relationship is a crucial human need. We are social beings and relationships with other people provide humans with a sense of humanness (Yalom & Leszcz, 2005). Literature on recovery from severe mental illness highlights social functioning and connection as key parameters which help contribute to positive outcomes in illness (Drake & Whitley, 2014; Shrivastava et al., 2011). From a social constructionist stance, healthy social relationships are important as they assist in constructing a sense of identity and self-worth.

People who are alienated will struggle to construct positive self-images and personal worth as society rejects them (Arboleda-Flórez & Stuart, 2012). It is thus important to create opportunities for isolated MHC users to be part of social groups where they are accepted and accepting of others in similar situations so that they can form worthy self-images.

This sub-theme illuminated the participants' experiences of social isolation and longing for connection. Their expressed need for social inclusion concurs with research conducted by Fleury et al. (2013a) who also identified interpersonal relationships as an important need for people living with severe mental illness. The support group offered the participants an opportunity to form social connections and friendships which have been shown to be important in the recovery process. The next sub-theme illustrates the sense of inclusion and belonging that the participants experienced in the context of the group.

4.5.1.2 Social connectedness and belonging: Socialisation, friendship, and a sense of belonging.

My interpretation of the participants' references to the socialisation and friendships that they experienced in the group is that the group provided them with a sense of belonging. The participants described how they celebrated birthdays together and how they enjoyed socialising over tea and biscuits after the group meetings. I felt this illuminated the sense of normality the participants gained from regularly attending group meetings, which was also a theme identified in first-person narratives of recovery as an important aspect in recovering from severe mental illness (Drake & Whitley, 2014). Within the group, the participants were in the presence of people with whom they could socialise and identify. The following extract from the interview with Participant 5 illustrates how the group setting provided him with a sense of belonging:

P5: *...it (the group) helps me because when we are in a group together—like when we are outside and because I'm mentally disturbed nobody wants me and I'm always alone...*

During the interviews in both the phase one and two, the participants provided an array of expressions which demonstrated the inclusive value offered by the support group. They made various references illustrating the enjoyment of socialising with each other. Participant 1 (P1) and Participant 3 (P3) made the following references to this during their phase one interviews:

P1: *...we did many things, we had fun. We were sharing things... we have fun there. We eat, we drink tea [laughing]... And we go to the movies [laughing]...*

P3: *…I enjoy when I am with them because I know I will only see them at that time only, it's not like I see them often. That little time I spend with them I enjoy…*

These experiences of connectedness contrast with the loneliness, alienation, and social isolation described in the previous sub-theme. Within the group, the participants were afforded the opportunity to enjoy social relations with other people. For people who felt socially isolated and excluded from their community, one can begin to appreciate how significant it must have been for them to have a group of people with whom they could experience normal everyday activities such as enjoying a cup of tea and sharing their special moments and birthdays. During the phase two interview with Participant 1, he made reference to a picture of a cake which represented the group members' birthdays they celebrated together:

> P1: *The cake. Okay. We used to have the birthdays for the group members... in the past. So this cake it represent* [sic] *each member's birthday… I think like—it's not easy to have a birthday, like, nobody ever had a best birthday. Even though you are the rich* [sic] *person in the world, you have all the money, but still, to have a birthday, I think it's still difficult* [laughing]... *So I think—I've chosen this one (picture) when we had the birthdays, and then, for us in the group it was like a surprise. And then we never thought that we could have that birthday cake* [laughing].

Here Participant 1 implied that sharing a birthday with friends is more important than money. He also mentioned that he thought having a birthday was difficult. In the previous sub-theme, Participant 1 explained how he lost touch with his friendship group when he became ill. For me, this extract illustrates the loneliness experienced on his past birthdays when he was without friends. He described his surprise when the group facilitators organised a birthday party for them and said that he had never thought it was possible to enjoy a birthday. Participant 1's description of his reaction to the birthday celebrations that took place in the group demonstrates the sense of normality the group provided the members. The group context offered opportunities for the socially isolated group members to once again experience normal life events such as birthday celebrations. In line with other research findings on recovery (Buchanan et al., 2014; Drake & Whitley, 2014) this highlights how important it is for MHC users to be able to experience a sense of normality to assist them on their journey to recovery. It further highlights the need for community-based resources which offer MHC users opportunity to participate in regular social activities in assisting them

to facilitate their integration into community life (MHCA, 2002; South African Department of Health, 2012).

Participant 2 similarly highlighted the value he attached to the birthday celebrations that took place in the group. He described a picture on his collage that was taken on his birthday when the group celebrated with him. He explained how excited he was when he received a birthday party in the group, illustrating the significance of the event:

P2: *This picture was taken when I* [sic] *was my birthday party.*

T: *How did you feel when you celebrated your birthday with other group members?*

P2: *I felt good… I choose this picture because I was—because I was excited when they—you do* [sic] *birthday for me… we were celebrating, all of us, eating cakes and drinking cold drinks…*

Moreover, participants 1, 3, and 5 all made reference to the sense of friendship they experienced in the group. This was significant to hear as the participants did not speak of their friendships outside of the group context. I felt that these participants' references to friendship within the group illustrated their social bonds and the sense of belonging that they felt. The following extract by Participant 1 during his phase two interview highlights the importance of friendships for human beings:

P1: *Yes, that was all about the friendship.*

I: *So that one* (picture) *represents the friendship?*

P1: *The friendship in a* [sic] *group.*

I: *And why is that important to you?*

P1: *...No individual can survive alone…*

Here, he illuminated his longing for social connections, highlighting that no individual can survive alone. The participants have all expressed experiences of alienation as a result of the mental illness but within the group they felt included and accepted. During their phase two interviews, participants 3 and 5 also expressed their sense of friendship in the group:

P3: *I've got a friend here sometimes...*

I: *Which friend? Who's your friend?*

P3: *No, all is* [sic] *my friend* [laughing].

I: *The group is your friend?*

P3: *Yes, is my friend.*

I: Okay. *Tell us about another image.*

P5: *And again I explain about—like-like with these, it's like a friend. We are together.*

It was noteworthy that the friendships of the members remained confined to the group context and that they did not socialise individually outside of the group setting. Both Participant 1 and Participant 3 referred to this during their phase one interviews:

P1: *...we are only friends there, it lasts there* (in the group). *When we go home, then… There in a* [sic] *community we are one.*

T: *Do you visit others in the group at their home?*

P3: *I have never made a visit to them.*

T: *Would you like to visit them?*

P3: *Ja, I would like to and also them to come visit me* [laughter]. *They may come and visit me.*

The group members only once socialised outside of the group setting in 2011. One of the group members (who had left the group) invited everyone to her home for tea after a group session. The group members later told us about their meeting during the following week's group. They indicated that they really enjoyed their social meeting outside the group setting. Other than that the group members never mentioned whether they socialised with each another outside the group. A possible reason could be that the participants struggle to co-ordinate, plan, and execute social engagements as a result of their mental illness which is a common consequence of psychotic conditions (Gard et al., 2014; Malchow et al., 2013). The structured organised opportunity provided by the group context, offered a space where they could socialise with others. Despite the friendships being limited to the group context, support groups can provide isolated MHC users an opportunity to connect with others and possibly form lasting friendships (Fleury et al., 2013b). Social support groups offer alienated MHC users a non-threatening context where they can meet and interact with other MHC users. Group meetings could thus afford MHC users the opportunity for friendship bonds to

develop as it offers structured meetings where they can meet new people. However, contradictory research findings by Meltzer et al. (2013) suggest that increased social support and opportunities for social interaction might be less beneficial in helping MHC users overcome feelings of loneliness than interventions targeting their maladaptive social cognition. These findings suggest that MHC users need additional forms of interventions to assist them in adjusting in the community. This could be provided in the individual therapy they received.

Finally, the following extracts by participants 3, 4, and 5 illuminated the sense of belonging that the participants felt within the group:

P3: ... *I'm enjoying the group to-to attend, to be with other members...*

P4: *...what I enjoy in this group is that when we are here we are happy together...*

P5: *...it helps me because when we are in a group together—like when we are outside and because I'm mentally disturbed nobody wants me and I'm always alone, but when I'm in the group, when we are together I feel alright because when you are alone all the time you will not live freely, and it's like you are not alright, but when in the group, I am alright.*

Participant 5 described how the sense of belonging he gained from being in the group helped him to feel less isolated from society, unlike the alienation and stigmatisation he

experienced in the community. The participants' feelings of connectedness within the group made them feel happy and good. Participant 1 described during his phase one interview how he felt about the group:

> P1: *I used to listen to Bob Marley's song. It was talking about like what a beautiful morning. I was feeling like, if I go to the group, that is a beautiful morning* [laughing].

The first theme encapsulates the participants' experiences of social exclusion they experienced in their community and the sense of belonging they felt within the group setting. Their references to friendships and their appreciation for being able to experience social activities with others demonstrated the sense of normality the group brought to the participants who expressed social isolation in the community, an important aspect linked to the recovery process (Drake & Whitley, 2014; Shrivastava et al., 2011). From a social constructionist stance, the group seemed to offer a sense of belonging which contributed to positive self-worth.

4.5.2 Theme 2: Mobilisation and stimulation.

The second theme demonstrates the value offered by the group project and activities. The fundraising project provided the group members an opportunity to set a goal and take responsibility for achieving that goal. The group outing served as the reward and offered them a chance to enjoy the efforts they put into reaching their goal. The theme also highlights the value of group activities such as sports and games as tools that provided mental and physical stimulation.

Mental illness can have a negative impact on a person's general functioning, motivation and ability to set goals (Malchow et al., 2013; Snethen et al., 2012). In Theme 1, Participant 3 illustrated this. Based on the participants' interviews, it seemed that the group project and activities provided the group members with cognitive and interactional stimulation and opportunities to become mentally and physically mobilised.

4.5.2.1 Group project and outing: Opportunity for responsibility, ownership, and reward.

During 2012, the student facilitators introduced a fundraising project to the group. The students donated second-hand clothes which the members sold to raise funds for an outing to the movies. This activity provided a structured task for which the group members had to take ownership and responsibility. During his phase one interview, Participant 2 explained the concept of the project:

> P2: ...sometimes they bring us clothes, and we sell those clothes you see. And then we get money, after we get money, we then go to (mall) to watch a movie... now they have brought other clothes. They are going to be sold and thereafter we give the money to (psychologist) and she keeps the money safe for us and then when it's enough, it's when—then that we decide where to go...

With encouragement from the facilitators, the group members were mobilised to set themselves the goal of raising money to organise an outing for themselves. Setting a collective goal allowed the members an opportunity to encourage and motivate each other to complete the task. They could support one another to accomplish their goal. The group facilitators offered further support and encouragement and helped to monitor the progress of

the project. Research carried out by Gard et al. (2014) highlighted that people with

schizophrenia sometimes engage in less effortful activities compared with healthy people

acting as a control group in the study. They also found that people with schizophrenia set

less effortful goals. In addition, they found that people with schizophrenia sometimes

displayed inaccuracy in estimating the difficulties of tasks or goals which prevents them from

attempting certain activities. In the light of such findings, the value of the group project is

illuminated. The group members were inspired and encouraged to set a goal and the

facilitators were there to continuously motivate them to work towards reaching that goal.

The outing can be regarded as a pleasure-based goal. Gard et al. (2014) found that people

with schizophrenia engage more in pleasure-based activities and set goals which are pleasure-

based than other people, which could explain the group members' successful completion of

the project.

In addition, Participant 5 explained how the group project helped him to learn

something:

> P5: *The projects teaches us—like others who do not know about stuff*
> *here, they can be taught from beginner experience from project so that*
> *when they look for jobs, we can get hired or be able to go on with*
> *school…*

Participant 5 highlighted the experience that the project offered him. This

is someone who has been suffering from a severe mental illness since childhood

and had never had a job. He felt that he had gained some experience that might be

of benefit in finding a job or to continue with education. In addition to mobilising

the group members, the project also seemed to have benefits in terms of learning

new skills such as raising funds in this particular case. Participant 5 implied that

the involvement in the group project made him more functional and could

possibly help him to gain future employment. Based on this finding, one could

argue that the project could possibly assist MHC users with severe mental illness

to regain functionality which is compromised by the social deterioration, a

characteristic feature of schizophrenia; such assistance could enhance skill

learning and treatment outcomes (Medalia & Saperstein, 2011; Shrivastava et al.,

2011). The goal setting and fundraising activities of the project could also be

regarded as a way of incorporating learning in a psychosocial treatment activity

which could be regarded as a form of cognitive remediation for people with severe

and chronic mental illness (Medalia & Saperstein, 2011).

As a result of their conditions, the participants tend to live sheltered lives.

The group project and outing also offered them an opportunity to experience a

sense of autonomy. They managed to achieve their goal without the help or

supervision of their family members. During his phase one interview Participant

3 highlighted this:

> P3: ... *like the trip we had of going to* (mall), *I have never been there,*
> *it was the first time going there. They teach us of things I have never*
> *done...*

None of the participants had ever been afforded an opportunity to go to this particular

shopping mall before. Participant 1 described the group outing as a journey of exploration:

> P1: *We were travelling in a group—so, it was nice. It was err—ex-*
> *exploring, like a journey. From all—from like err—'cause we did*

something...   Even though we never thought that we—it was

something, but we reached that, err—we went there and then we

watched the movie, and then—in life people they like to be free and do

the-the [sic] *stuff on their own…*

My interpretation of the extract from the interview with Participant 1 is that of accomplishment and autonomy. He expressed that he did not think it was possible to reach their goal, but that their outing to the movies proved that it was indeed a great accomplishment. He also made reference to the importance of autonomy. Drake and Whitley (2014) similarly highlighted autonomy as being important in the recovery from severe mental illness. People with mental illness value that they have a voice and that they can become self-determining. All the participants spoke of the group project and outing. For me this indicated the significance and value they placed on the project and the outing. This illuminated the mobilisation it offered them to take ownership of and responsibility for a collective goal and celebrate their accomplishment together as a group.

4.5.2.2 Group activities: Tools for physical and mental stimulation.

In addition to the group project and outing, the participants mentioned the games, sports, and exercise they participated in during group sessions:

P1: *...playing soccer, it was nice.*

P2: *...we were playing cards, playing games of putting square blocks*
of wood on top of each other…

I: *So why did you pick that picture to represent the group?*

P3: *Yes, I was thinking we was-we were playing here.*

P4: *...we were exercising… we also played soccer too*.

Approximately six months after the group's initiation, my co-facilitator and I conducted a second needs analysis with the group members to ensure their needs were being fulfilled. It was then that they expressed their desire to include group activities such as games and sports. This was an indication of their need for mental and physical stimulation. Sports and games were thus additional tools to help mobilise and stimulate the group members. The physical activity provided by the exercise and mental stimulation provided by the games (Bingo, Jenga, Uno, and other card games) helped the participants to experience a sense of enjoyment which contributes to positive feelings.

There is supporting evidence highlighting the value of physical exercise as add-on treatments for patients with severe mental illness such as schizophrenia and affective disorders (Malchow et al., 2013; Vancampfort et al., 2012). A systematic review by Vancampfort et al. (2012) affirmed that there is evidence to support that aerobic exercise reduces psychiatric symptoms, anxiety states, and psychological distress, as well as to improve health-related quality of life for people with schizophrenia. Furthermore, Malchow et al. (2013) reported on the benefits of exercise on severe mental illness. Benefits included reduced symptomology and positive effects on cognitive functioning such as improved attention and executive functioning.

The participants illuminated the value of the group fundraising project and outing as well as the group activities such as soccer, exercise, and card games. They reported finding benefit in these activities by means of experiencing a sense of enjoyment and from learning and exploring new things such as raising funds and going on an outing. This theme thus demonstrated the ways in which the participants were mobilised and stimulated both mentally and physically by the group project and activities. In the light of supporting literature indicating a lack of motivation amongst MHC users, the group assisted the members to become mobilised and stimulated, which could contribute to an increased sense of quality of life (Fleury et al., 2013a; Malchow et al., 2013).

4.5.3   Theme 3: A source of support.

This theme highlights the various means of support that play a role in the treatment and maintenance of mental illness. Medical support offered by PHC clinics and community health centres, as well as the governmental disability grant, provide MHC users with some means of support to help them cope with the devastating effects of severe mental illness. Social and emotional support structures on the other hand are often limited (Drake & Whitley, 2014). The participants highlighted the group as an important source of support in their lives. They mentioned receiving support from the psychologist and the psychiatric nurses, the facilitators, and one another.

4.5.3.1 The role of medical and financial support in the maintenance of mental illness.

The multilayered effects of severe mental illness extend far beyond the symptoms of the condition and affect MHC users in various domains of life (Rajji et al., 2014). Impaired cognitive and social functioning, self-care, feelings of loneliness, and ability to earn income

are only some of the aspects that are affected (Moriarty et al., 2012; Rajji et al., 2014; Simpson & Sambuko, 2011). Various support structures are therefore instrumental in the treatment and effective maintenance of mental illness. Tsai et al. (2012) highlighted how many adults with severe mental illness rely on support from public MHC services and professionals to help meet their treatment, social support, and financial needs. During his phase two interview, Participant 5 similarly illuminated the various means of support provided by government structures instrumental in helping him cope with his condition:

> P5: *...the first one* (picture) *I chose because the government helps us a lot. If it wasn't for the government I do not know what would have happened... The medication helps us. And again we are helped by the government, you see...*

For MHC users such as the participants who are of lower socioeconomic status and cannot afford medical aid, PHC services are the only source of medical help and support they have access to. Participant 5 highlighted the importance of this support when he explained that he did not know what would have happened to him without the support from government. He also mentioned how the medication helped him. Psycho-pharmacological treatment plays an important role in reducing psychotic symptoms and is freely available from community clinics and CHCs. The government also provides access to MHC professionals and hospitalisation when required.

As pointed out in the literature review, many MHC users also experience job loss and unemployment as a result of their illness (Mathews et al., 2013; Rajji et al., 2014). Financial support provided by governmental disability grants offer MHC users with some financial

assistance to address some of their basic needs. Participant 5 also pointed out how the group

was made possible through government structures:

> P5: *The government helps us with the illnesses and the grants and it*
>
> *can also help us in the group—that we can be here today in the group*
>
> *is because of the government...*

Participant 5 illuminated the value of medical and financial support offered by

government structures. Literature highlights that additional services such as assisted

employment and peer support are also instrumental in the process of recovering from mental

illness (Drake & Whitley, 2014; Fleury et al., 2013a). Research findings by Fleury et al.

(2013b) pointed out that supportive social networks help to increase the subjective quality of

life of MHC users. The support group can be considered to be an additional community-

based service to assist MHC users in out-patient settings to cope and recover from their

conditions. The participants particularly illuminated the value of the social and emotional

support they received from the group.

4.5.3.2 Social and emotional support provided by the group.

There is literature which highlights the importance of social and emotional support for

MHC users in maintaining positive mental health outcomes (Tsai et al., 2012). Some

emotional support stems from the family unit, but for many MHC users social and emotional

support is often limited. Furthermore, literature asserts that people with severe mental illness

have smaller social networks which are less reciprocal and contain more MHC professionals

(Tsai et al., 2012). The participants highlighted the group as an important source of support

in their lives. Support was offered by the MHC service providers who were involved with

the group, the group facilitators, as well as the group members.

As highlighted in the literature review, limited MHC staff and high patient loads do not allow sufficient time for follow-up sessions with service users (Botha et al., 2008). In-depth follow-up interviews are essential to determine how well MHC users are managing their symptoms, treatment plans, and side effects. The follow-up interviews also allow MHC service providers a chance to identify relapse early and prevent the need for re-hospitalisation. The participants highlighted that the support group provided a space where additional support could be obtained from the services providers (such as the psychiatric nurses and the clinical psychologist) when they were offered the opportunity to attend group meetings. During her phase 2 interview, Participant 4 highlighted the support she received by the psychologist and the psychiatric nurses during the group meetings:

> P4: *It reminds me of* (psychologist), *the time I was stressed and she called me into her office and asked me how am I and also asked me questions and also gave me advice. She told me not to think too much, remove old stressful things from my heart, the way I was living...*

> T: *This photo of* (psychologist), *why is it important that it should represent the group... in these pictures?*

> P4: *It's important because* (psychologist) *was giving us advice and she was supporting us in the group...*

Here Participant 4 spoke about the time she rejoined the group a couple of months after attending the initial group meeting in 2010. The psychologist also attended that session and identified that she needed additional individual attention. Identifying her behaviour within the group setting, which allowed for additional intervention and treatment, possibly prevented her from relapsing and from being hospitalised. Group attendance by out-patients

increases contact with health care professionals and peers and could thus help in monitoring

symptoms and assist in early relapse identification.

Moreover, the following extracts by Participant 4 illuminates the role of the follow-up

interviews with the psychiatric nurses. She was explaining a picture on her collage which

represented one of the psychiatric nurses who had recently retired:

> P4: *I chose it* (picture) *because* (sister) *was nearing her retirement
> and this year she retired and she doesn't come anymore, so I
> remember her with it.*
>
> T: *What is this picture's importance to represent* (sister) *in the group
> photo?*
>
> P4: *Its importance is that when I came to the clinic to collect my
> medication she would ask me how I feel, am I sleeping well, is the
> medication treating me well, do I sleep well, do I eat well?*

Participant 4 highlighted the importance of the follow-up interviews with the

psychiatric nursing staff. The group setting offered an additional space where group

members could share difficulties and ask advice. The value the group members attached to

the support of the mental health professionals is in accordance with research conducted by

Tsai et al. (2012). These authors reiterated that people suffering from mental illness relied

more on professionals for support which suggested that MHC services possibly provide

substitute social support for them. They explained that people with severe mental illness

might have taxed relationships with friends and family which are less reciprocal in nature and

as a result they turn to mental health professionals to compensate for the lack of supportive

networks in their lives.

The participants also spoke about the support they received from the group

facilitators. Before joining the group, the participants reported feeling lonely and isolated.

The availability of the group facilitators made the group experience possible as the MHC

staff did not have time to initiate and facilitate weekly group meetings as highlighted in our

initial contact meeting in 2010. During his phase one interview, Participant 3 spoke about the

role of the group facilitators and what it meant to him:

> P3: *... it does console me. I would be sitting and watching the white*
>
> *people come* [laughing]. *They ask us questions—others we can answer*
>
> *others* [sic] [laughing]... *I see them playing with us games, here and*
>
> *there, and we talk. They* [sic] *also those who we were with, they tell us*
>
> *how their weekend was and stuff like that, and we explain to one*
>
> *another...* *...it's these nurses* (facilitators) *that helps* [sic] *us...* *they*
>
> *make us play games, it's them who teaches us games, they console us*.

Participant 3 illuminated the support provided by the group facilitators as being of

consolation to him which highlights his reliance on professional networks for social support.

The extract of the interview with Participant 3 illustrates the supportive value offered by the

presence of the group facilitators, interacting and conversing with the group members who

sometimes feel rejected from their community. Participant 3 joined the group because of his

extreme social isolation and he described how much he appreciated the role the facilitators

played in the group. This finding is in line with the work of Tsai et al. (2012) who affirmed

that individuals with more severe symptoms were less socially integrated. This suggests that

severe psychopathology may interfere with social relationships and increase MHC users'

reliance on professionals for support. Participant 1 described a similar appreciation for the

group facilitators during his phase one interview:

> P1: *...you as a group you are helping us, and then you group leaders*
>
> *we are* [sic], *uhm, you don't get angry with us, but you always accept*
>
> *the way we are* [laughing]... *We forget things, we've got side effects,*
>
> *we've got many things on our plates that we cannot manage*
>
> [laughing]...
>
> I: *Does the group help you with that?*
>
> P1: *You, the group leaders, you help us with that* [laughing]...

Participant 1 described the group facilitators as being patient and accepting which

possibly suggests his taxed relationships with family and friends (Tsai et al., 2012). He

described the supportive role the facilitators played in the group. In the group setting, with

the help of the facilitators, the group members could receive additional support, advice, and

attention in addition to that provided by the MHC service providers during follow-up

interview appointments.

The group setting also allowed the members to offer peer support, another aspect

highly valued by people suffering from severe mental illness (Drake & Whitley, 2014). The

group members could express troubles and offer each other support and advice. Peer support

is based on the notion that individuals who share similar experiences are in the ideal position

to offer one another emotional and informational support as they possess unique knowledge

and potential advice based on their shared experiences (Castelein et al., 2008). During both

the phase one and two interviews, the participants made various references to the forms of support they offered and received from their fellow group members. During his phase one interview, Participant 1 mentioned how the group supported him with his studies:

> P1: *I'm still fighting to get my—to get-to go to the university.*

> I: *And how does the group help you with that?*

> P1: *Being with them, sharing...*

Participant 1 explained how sharing his difficulties and success that he experienced with his studies was of value to him. Research undertaken by Maulik, Eaton, and Bradshaw (2010) also highlighted the value of social support in reducing psychological distress caused by certain life events. Participant 1 received support from the group to help him cope with the stress of his studies.

During her phase one interview, Participant 4 described how the group supported Participant 3 with his substance abuse:

> P4: ...(participant 3) *was the one giving us trouble because he was smoking marijuana. We were supporting him...*

The group members would explain to Participant 3 that his substance use interferes with his treatment plan and they would encourage him to stop smoking marijuana. The group represented a supportive space in which he received assistance to help quit his habit of smoking marijuana; for example, taking up a hobby and keeping himself busy in constructive ways.

During his phase two interview, Participant 5 also explained how the group offered him strength and advice. He could share problems with his fellow group members who experienced similar experiences of stigmatisation and loneliness:

> P5: *... when we are in the group we can give each other strength and advices... and when someone has a problem we can talk about our problems... the hospital helps us with the medication and the group members with advice...*

This theme illuminated the various support structures instrumental in maintaining positive mental health outcomes. Medication assists with the maintenance of symptomology. Government grants offer financial support. Social and emotional support were provided by the MHC professionals, the facilitators, and the group members. Because people with psychosis often have small social networks which limit their opportunities to share their experiences with others, it is of great value and importance to offer community-based support groups for MHC users as social support has potential beneficial effects on relapse, symptomology, social networks, and quality of life (Fleury et al., 2013b).

4.5.4 Theme 4: The learning experience.

This theme encompasses the various forms of learning that took place in the group context. Structured learning took place by means of psycho-educational group discussions and experiential learning emerged amongst the group members through the sharing of stories and personal experiences. The participants also reported a sense of healing they experienced as a result of being in the group. The participants' sense of healing suggests the rehabilitative value of the various forms of learning that took place within the group.

4.5.4.1 Psycho-education.

Psycho-education entails providing knowledge, skills, and therapeutic strategies that can subsequently improve functioning and increase MHC users' abilities to maintain positive health (Chadzynska & Charzynska, 2011). During the initial needs analysis conducted with the group members they highlighted their need for psycho-education. They wanted to learn more about diseases such as HIV/Aids, heart disease, tuberculosis, and about side effects of medication. The group members' desire for additional knowledge concurs with research participants in a study carried out by Chadzynska and Charzynska (2011). The main reason participants reported for participating in psycho-education groups in their study was their need to gain information to increase self-knowledge of their illness and to create ways of coping. Discussing various topics offered the group members the psycho-education they desired. During the phase one interviews, participants 1 and 2 gave examples of the psycho-education that took place in the group setting:

> P1: ...(other 2012 group facilitator) *gave me a certain book, the abnormal psychologist* [sic] *book... Is like err, 'cause we were going to discuss about* [sic] *the drugs*.

> P2: *Group was showing us everything, they were telling us about side effects, depression, and TB... and HIV also... It was good being in the group because I now know about illnesses. They told me about illnesses and how to prevent them.*

These participants explained how they learned more about mental illness, other medical conditions, and preventative measures from the group discussions. There is evidence

that psycho-education is associated with a number of rehabilitative benefits namely increased

knowledge about illness, improved health and psychosocial functioning, better treatment

adherence, and reduced relapse (Chadzynska & Charzynska, 2011; Katakura et al., 2013).

During his phase two interview, Participant 3 explained how the group taught him about the

dangers of alcohol and how it interferes with the psycho-pharmacological treatment:

> P3: *...they was* [sic] *telling me about alcohol and not drinking alcohol.*
> *The way alcohol—they put you to be bad* [sic] *with drinking... They*
> *say—eh, they say when you drink too much, you will never drink the*
> *medication.*

The group taught Participant 3 about the detrimental effects of substance use on

treatment adherence and psychiatric symptoms. The psycho-educational discussions allowed

the facilitators as well as the group members to share information and knowledge and learn

from each other. Educating MHC users equip them with knowledge to help them manage

their health and well-being and in turn could help promote their autonomy which is an

important aspect in the recovery process (Drake & Whitley, 2014; Katakura et al., 2013;

Snethen et al., 2012). The following extract from the interview with Participant 3 further

illustrates the value of the group psycho-education in assisting MHC users to maintain

positive mental health outcomes:

> P3: *...they taught us and we were exercising and getting taught about*
> *mental—the brain, and that you have to drink the pills... And if you*
> *don't drink the pills, what sort of person you are going to be... You*
> *will end up going back to the hospital again... ...they give* [sic] *us*
> *knowledge to save ourselves...*

Katakura et al. (2013) assert the importance of providing MHC users with knowledge to help them manage their medical conditions and daily living in community settings. Many MHC users struggle with other physical health related conditions such as cerebrovascular diseases, diabetes mellitus, and respiratory diseases in addition to their mental illness (Katakura et al., 2013; Scott & Happell, 2011). Research participants in the study by Katakura et al. (2013) highlighted the importance of acquiring knowledge of both psychological and physical health for them to help them maintain their health. The authors were of the opinion that MHC professionals should be aware of service users' needs and provide them with the knowledge and skills needed to maintain their health. The support group provided an opportunity to apply this concept.

4.5.4.2 Interpersonal learning.

The participants highlighted the interpersonal learning that took place between them. Sharing stories and experiences they could relate to, provided a context for this interpersonal learning to take place. The following extract by Participant 1 illustrates how sharing experiences in the group taught him about life and the reality:

I: *What sort of stuff did you share in the group?*

P1: *What affect* [sic] *us in the community. Like we—there were many challenges there in the community, like when people are doing drugs, drinking. Sometimes when people are stressed—they've got stress, it's like they drink alcohol, like they go to the beers* [sic]. *They think it's the only way to relieve themselves. They—but they drink beers. Uhm, in the community. And then people they are like—they've got anger... They are always like stressed. When their problem—their problem*

> *they hurts* [sic] *them.   Hurts them* [sic] *,they-they just use people as*
>
> *punch bags.*

Participant 1 was referring to the personal experiences that were shared between the group members. The members shared their personal experiences and troubles in the group. Participant 1 explained here how he learned how to deal with reality by means of hearing the stories from other group members. Because the group members shared many similar experiences they could relate to each other in many ways.

During her phase one interview, Participant 4 explained how she taught the group members exercises and songs and how she also learned from Participant 1:

> P4: *...And then we were exercising. I was teaching them exercises and*
>
> *also songs and exercising, and I showed them what I know and they*
>
> *did it...* (Participant 1) *was alright and he was also educated, so most*
>
> *of the time where I did not understand I would ask him and he would*
>
> *explain to me...*

She also explained how she advised Participant 3 not to smoke marijuana as it could cause him to lose his grant:

> P4: *...I told him to drink his medication properly and that he* [sic] *stop*
>
> *smoking ganja so they do not stop his grant money.   But he is*
>
> *behaving okay. He is clean and is looking after himself...*

During his phase two interview, Participant 2 illustrated the interpersonal learning that took place in the group setting through the psycho-educational group discussions. He explained a picture of tooth paste he used on his collage:

> P2: ...*This one I take it because I can wash* [sic] *my teeth.*

> I: *And why did you choose this picture as a representation of the group?*

> P2: ...*I showed them they must use Colgate...*

Snethen et al. (2012) tested the outcome of the Independence through Community Access and Navigation (I-CAN) intervention on people with schizophrenia spectrum disorders. The model is grounded in self-determination theory which suggests that meeting basic psychological needs of autonomy, competence, and relatedness are fundamental for motivation and well-being. In this context, relatedness entails a person's need to be connected to others and to be an equal contributor to relationships (Snethen et al., 2012). The participants' references to the interpersonal learning experiences that took place in the group suggests the value they placed on being able to contribute knowledge and advice to one another. This in turn implies the value of interpersonal learning potential of support groups to assist MHC users maintain positive health outcomes.

Participant 5 also illustrated interpersonal learning that took place amongst the group members during his phase one interview. His extract describes a time when he shared personal problems he experienced in the community and how the group members advised him how to deal with his situation:

> P5: ...*this group helped me with advice after I explained to them about problems I'm experiencing where I stay, and so they told me not to be fazed by them and only look at my medical state...*

The group members related to many of each other's experiences and troubles as they all suffered from severe and chronic mental illness. The group members possessed valuable input and advice which they could offer and which they shared with each other. The sharing of stories and experiences provided a means for interpersonal learning to take place. This extract from the interview with Participant 1demonstrates the common experiences shared amongst the group members:

> P1: *I was human like them. What they were facing—some of the other things that they facing* [sic], *I was facing them as well.*

This extract illuminates the notion of peer support which is based on the premise that people who share similar experiences can offer one another relevant advice based on their unique understanding of their shared experiences (Castelein et al., 2008).

4.5.4.3 Rehabilitation.

The participants expressed a sense of healing which suggested the rehabilitative value of the group. Psycho-education is a well-established form of treatment and rehabilitation for people suffering with mental illness (Chadzynska & Charzynska, 2011; Katakura et al., 2013). The psycho-education and interpersonal learning that took place in the group seemed to have assisted with the participants' sense of healing. Here are some extracts illustrating the participants' rehabilitation:

> P2: *My life is different because I drink the pills—And err* [pause] *my life come* [sic] *alright… I don't see any more, I don't hear any more voices.*

Participant 2 shared how being in the group changed his life. He said he does not

experience hallucinations anymore because he is taking his treatment properly, suggesting

that the psycho-education assisted with his treatment compliance. This extract demonstrates

the rehabilitative value of the psycho-education on symptomology. This is of value because

treatment adherence is a well-known difficulty among people suffering with psychosis

(Castelein et al., 2008). This supports the need for psycho-education which could increase

treatment compliance and prevention of relapse among MHC users. On the contrary,

Chadzynska and Charzynska (2011) did however note that increased knowledge among

schizophrenia patients might contribute to lower quality of life as it could increase the level

of self-criticism toward their illness.

Participant 3 explained how the games and activities helped to improve his mental

functioning:

> P3: *...some games—my mind was functioning very well, when we* [sic]
> *playing we gain some knowledge.*

> I: *What knowledge do you gain from playing games?*

> P3: *Yeah, good knowledge, your mind works very well, doesn't stop.*
> *At least it learns something.*

> I: *So the games helped you to learn stuff?*

> P3: *Yeah, to learn, yes…*

Participant 3 already illustrated his experiences of avolition which is characteristic of

schizophrenia (Snethen et al., 2012). He explained how some mornings he did not even feel

the need to wash. Here he suggested the rehabilitative value of the group activities. He felt that it assisted with improving his mental functioning. Avolition and cognitive impairment associated with psychosis have a negative impact on quality of life (Malchow et al., 2013; Moriarty et al., 2012). In addition to stimulating the group members physically, Participant 3 also illuminated the rehabilitative value it can have.

The participants also expressed the rehabilitative value of the interpersonal skills they gained from the group. Participants 2 and 4 shared how the group taught them to communicate better with others indicating the communication and listening skills they gained from attending the group sessions:

> P2: *What has changed is that they are no longer taking me to Weskoppies. I'm now able to speak to people, communicate with people...*

> T: *...what did this group teach you?*

> P4: *Eish, oh. It taught me on how to talk to people…*

When conflict arose, the group facilitators were there to model appropriate ways of dealing with it. Participant 4 illustrated how the group helped her to improve relationships with her son and neighbours and to be less confrontational and live in harmony with others:

> P4: *My life has changed because the time I wasn't involved in the group I was living—I wasn't living a good life. I was always fighting with my child at home and then even people outside when I see them I would be angry with them. When they speak* [sic] *to me I got annoyed*

and swear [sic] *at them … We now live happily, even my son doesn't*

give me trouble anymore. He listens to me and we live in harmony.

We are not fighting, he respects me. We live in peace me and her [sic].

The group setting offered the participants a context where much learning and rehabilitation took place. All the participants indicated that they have learned many things from being in the group and they shared feelings of being healed.

P4: *It* (the group) *really helped me because I felt healed and taking my treatment and I'm loved by people... I feel happy and I feel cured, and no more seeing* [sic] *myself sick again.*

This theme illuminated how the group provided opportunities for learning to take place and for the participants to contribute to the learning experiences. It also demonstrated the rehabilitative value of the learning and education that took place in the group suggesting the value of community-based support groups in helping MHC users recover from their conditions both psychologically and socially.

4.5.5   Theme 5: Transformation and growth.

The final theme illustrates how the participants' involvement with the group contributed to their transformation and growth, assisting them in their recovery from severe and chronic mental illness. It illuminates the difficulties, limitations, and losses they experienced as a result of their conditions and how they managed to regain a sense of hopefulness for the future.

4.5.5.1 Societal discourses and self-stigmatisation.

The first sub-theme demonstrates how the participants were influenced by the negative societal discourses around mental illness. It appeared as if the stigmatisation they endured in the community was internalised, leading to self-stigmatisation. During the group sessions and data collection interviews the participants highlighted some of these discourses. The following extracts illuminate the extent to which these societal discourses influenced how they referred to themselves as individuals living with mental illness:

P1: *...we are mad* [laughing].

P2: *I once went to, where the crazies stay... Mal hospitaal* [sic]... *Weskoppies*.

P3: *They take me there to Mal hospitaal* [sic], *the first time on GaRakuwa Mal hospitaal* [sic], *they take me on* [sic] *Weskoppies*.

P4: *...what do they call mental illness in English, they say it's mental what? ... Mental—it's, eh, of being crazy.*

References to people with mental illness such as being crazy, mad, insane, weak, or incapable of doing things for themselves are still prevalent in society (South African Department of Health, 2012). The African notion regarding the aetiology of mental illness also entails negative connotations for example being bewitched or punished by the ancestors for doing something wrong (Burns et al., 2011; Mzimkulu & Simbayi, 2006). Arboleda-

Flórez and Stuart (2012) reiterated the stigma discourses that prevail in modern day society despite all the MHC transformation and focus on recovery-based models. These notions have negative implications regarding the identity of the MHC users. The extracts from the interviews with the participants illuminate this. Furthermore, the participants referred to the psychiatric hospital as the "Mal hospital", which depicts the negative connotations of having a mental illness in the community in which the participants live. This can be explained by the social constructionist notion that people shape their identities according to societal discourses. Katakura et al. (2013) also highlighted how individuals can internalise societal discourses. They were of the opinion that the traditional Japanese proverb stating, "He who does not work shall not eat", motivated their working aged participants to obtain a job in the future. The extracts from the interviews with the participants also indicate how personal identity is shaped by societal discourses as illuminated by their self-stigmatisation when they referred to themselves as crazy and mad. The participants' personal references to being crazy or mad suggest that they have internalised this stigma. Internalised stigma among MHC users has been associated with compromised self-confidence, defensiveness, avoidance, and social isolation (Arboleda-Flórez & Stuart, 2012; Moriarty et al., 2012; Snethen et al., 2012).

4.5.5.2 Lost dreams and the limitations caused by mental illness.

In addition to the stigmatisation that the participants endured, they also described the debilitating effects of their mental illness on their overall functioning. The participants expressed the losses they suffered as a result of their conditions. During his phase one interview, Participant 1 described the limitations of mental illness:

> P1: *We are depending on medications... our minds are no longer*
> *function—are no longer functioning well... We forget things, we've*

got side effects, we've got many things in [sic] *our plates that we*

cannot manage [laughing].

Participant 5 also described the limitations of mental illness during his phase two interview:

P5: *There are some things we do not see. In most cases we see these*

things only on television and others cannot reach them because they

are mentally ill and they [sic] *afraid to travel alone, you see.*

These extracts illuminate some of the challenges endured by the participants such as side effects, difficulty coping with stress, cognitive impairments, and reduced agency and autonomy. Participant 5 explained how he is sometimes afraid to travel by himself and how it confines him to his community. The feeling of little control and autonomy have been negatively associated with the recovery process (Drake & Whitley, 2014).

The participants also described how their illnesses prevented them from reaching some of their childhood dreams. During their phase two interviews, Participant 1 described a picture of priests and Participant 3, a picture of a plane as representing their lost dreams:

P1: *...when I was a young—I was a child—I wish to become like one*

of this... [Pause] *One of these bishops* [laughing] *...the first time I was*

in the group—I use to talk that in the past, I wanted to be something

like this, but I failed... I used to talk about that in the group—

I: *Ah, so it reminds you of stuff that you discussed in the group?*

P1: *Uhm. But that—what I-I was supposed to be like, but I-I failed.*

P3: *I was thinking to be a pilot but I'm damned at* [sic] *the head...*

Participant 1 described how he shared his difficulty of his lost childhood dream in the group. This further illustrates the supportive role that the group played in the lives of the group members in helping them to cope with loss and grieving parts of the dreams that they could not attain. The group provided a context where the group members could share their troubles with others and express how they felt about the restrictions of their mental illness. Conditions such as schizophrenia and affective disorders are associated with a range of impaired cognitive functions which in turn contribute to the deterioration of social skills, and reduced autonomy, as well as occupational related problems and difficulties (Malchow et al., 2013). As a result, many people suffering with mental illness have to come to terms with the limitations of mental illness on their dreams and goals. Shrivastava et al. (2011) highlighted that performing social functions such as having a job and earning an income reflects one's ability to live in society and perform socially expected roles. It offers MHC users a sense of normality and can impact positively on self-esteem and self-worth. This provides evidence for the importance of providing MHC service users with community-based services and resources to assist their social functioning.

4.5.5.3 Desire for normalisation and identification with social norms.

The participants also expressed a need for normalisation, living a normal life with other people, and having the autonomy to do things without the supervision of their family members. The following extracts by participants 1 and 4 during their phase one interviews illuminated their need for normalisation:

> P1: *One day I watched a film about a film that—as a-in a movie. They say I'm a slave. A girl, she said she was a slave. I-I-I felt like that. I don't want to be a slave... I want to be on my own... I want to be strong, to challenge any-anyone in the world, and then I want to be more powerful.*

> P4: *I just wanted help in order for me to live a normal life with other people.*

The participants also indicated their identification with social norms. During her phase two interview, Participant 4 illustrated how she identified with social norms when she explained a picture of a model she used in her collage:

> P4: *I love this dress and this bag and these shoes.*

> I: *Okay. But why, err how is that important as a representation of the group?*

> P4: *It's important because this girl is well dressed—shows us how we should behave... It means we must look after ourselves, be immaculate... We must wear dresses, skirts, and jeans.*

Participant 2 also illustrated how he identified with the social norm of getting married and having a family when he explained a picture of a ring in his collage:

> P2: *...when group member* [sic] *is married—he must get married, and then when he is married he must have a family and a wife... ...the other groups* [sic] *must also marry.*

> I: *Ah, okay. And why do you want the other group members to also marry?*

> P2: *Because I'm married myself.*

Participant 2 shared his wish that the other group members could also be married and have families like him. For many people living with severe and chronic mental illness it is not always easy to live up to the norms and standards prescribed by society. Participant 3 illustrated how he also identified with social norms such as having a job and a girlfriend but how these desires were complicated by his mental illness:

> P3: *Yes, eish.* [Pause] *I was thinking many things, a lot... I was thinking about me, maybe I cannot get a job or something. Or maybe a girlfriend* [laughing].

Here, Participant 3 explained how he was thinking about his future. He expressed his concern that he might never get a job or meet a girlfriend. All the extracts provided in this sub-theme illustrate how the participants identified with social norms and desires for normality.

4.5.5.4 Hopefulness for the future.

In addition to the participants' expressions of their lost dreams and limitations associated with their conditions, they also shared various aspirations. These included looking

forward to the group outing, taking overseas trips, learning how to read and write English, finding jobs, and getting a car. I felt that their expressions of their aspirations illustrated their hopefulness for the future.

> P1: *I wish one day I-I could go to, like Italy. I could go to, Vatican City.*

> P2: *This time we've planned that maybe we can go to the zoo if we get money.*

> P3: *Ah, this is not the group this thing, this one. I would love to-to—I would love to ride-drive* [sic] *a horse.*

> P4: *I loved school. I was a person who attended school and I was intelligent. In the group I would really like it if they teach us school stuff, to write and to speak English properly.*

Despite the negative societal discourse regarding mental illness and the stigmatisation that the participants experienced, as well as the limitations and losses they had to endure as a result of their mental illness, they still expressed hopes and dreams for the future. For me this illustrated transformation and growth. Their expressions of aspirations they wish to achieve represent their resilience suggesting that they did not give up on life despite living with severe and chronic mental illness. They provided expressions of their beliefs that they could still achieve their goals and accomplish their dreams. Fleury et al. (2013b) referred to

recovery as involving the creation of new meaning and purpose in a person's life as one grows beyond the catastrophic effects of mental illness. I feel the participants' aspirations demonstrated this and that the group context assisted them with a supportive environment to achieve this.

The group provided a space where the participants could share their hardships and triumphs. According to the social constructionist notion, identity is fluid and individuals can construct new identities when provided with a context where they can challenge the dominant societal discourses and renegotiate new self-constructs (Raskin, 2002; Shotter, 1997). From my journey with the participants I truly believe this was made possible within the context of the support group.

> P1: *I think the only way to make the group better is by us* [sic] *as group members to stand up, to show the doctors that we are not that sick. If the doctors are thinking that we are more psych—we are so sick, very, very sick. That we—one day we can be like them and be the doc—the future doctors, the psychiatrists, the psychologists, the occupational therapists, all the professions in the world* [laughing]. *That we can be still even though we are mad* [laughing]. *That one is-is our hope* [sic].

This extract from the interview with Participant 1 echoes the resilience demonstrated by the participants despite all the challenges they endured. The sub-themes included here encapsulate the participants' progression from predominantly negative to more positive discourses expressed by them. Their self-stigmatisation was followed by the acknowledgement and acceptance of lost dreams and a range of challenges associate with

mental illness which made it difficult for them to live up to the general societal expectations such as having a job, getting married, and having a family. I felt that the participants' expressed aspirations echoed their resilience and indicated their desire and efforts to recover from their mental illness.

4.6   Chapter Summary

This chapter provided a detailed description of how the data sets were prepared for analysis as well as the steps taken in the analysis process. The process of co-created meaning making was explained so as to shed light on the approach taken to construct the themes and sub-themes presented here. The research participants were introduced and demographically described to furnish some context of the meaning making agents participating in the construction of the group's meaning. The main findings were presented and discussed in the light of existing literature.

In summary, the themes and sub-themes presented in this chapter suggest that the group offered the participants with a sense of belonging, opportunities to be mentally and physically mobilised and stimulated, as being an important source of support in their lives, as offering opportunity for learning and rehabilitation, and contributed to a sense of hopefulness for the future.

Chapter 5

Conclusion and Recommendations

5.1   Chapter Overview

This chapter concludes the report with final reflections and remarks,

recommendations for future research, as well as the study's strengths and limitations.

5.2   Final Reflections and Concluding Remarks

In order to conclude the research, I arranged a debriefing group session with the

participants to allow them an opportunity to comment on the findings and offer their

reflection on their involvement in the research process (see Appendix 5 for the reflective

notes). Member checking is described by Creswell (2014) as a validity strategy to ensure the

accuracy of one's findings. Moreover, I felt compelled to offer the participants an

opportunity to hear their stories which I had the privilege to co-construct and report on.

While making arrangements for the debriefing session I contacted one of the 2015

group facilitators to ask her to accompany me to the session for translation purposes. I sadly

learned that three of the participants had experienced recent relapses. The challenge of living

with a chronic and severe mental illness occurred to me once again. Learning of the relapses

further reiterated the need for additional MHC services and community-based resources

required to assist service users to cope with their conditions.

Only three of the five participants arrived for the session. I failed to make contact

with Participant 4 and Participant 2 who were recovering from a recent relapse. I explained

that the purpose of the session was to share the findings and allow them the opportunity to

comment and find out whether they agreed with my interpretation. I firstly shared each participant's biographical background and asked them to confirm whether the information was accurate. Only Participant 5 suggested two minor changes to his biographic description. All three participants agreed that they were happy for me to share their personal information.

Next, I discussed each theme and explained how I co-created meaning with them based on the information they shared during the data collection interviews. All three participants agreed with the themes and felt that everything was true and accurately reflected the meaning they ascribed to the group. Only Participant 3 commented on the final theme and felt that he had no hope for the future. Participant 3 had experienced a recent relapse and this might have been why he felt hopeless at the time. The comment by Participant 3 again reiterated the need for more community-based rehabilitative services to help MHC users reintegrate into community life as contributing citizens.

The findings generated from this research no doubt demonstrated the value the group had for the participants. They highlighted that the group offered them a sense of belonging in contrast to the alienation and rejection they endured in their community. Theme two illuminated the value of the group projects and activities in assisting the members to become mentally and physically mobilised. Moreover, it offered the participants extra support, a space for them to share their challenges and ask for advice from others who could relate to their situation. It also offered a context for learning and teaching each other by means of sharing experiences and knowledge. Finally, my interpretation of the participants' future aspirations was that they had the ability to remain hopeful regarding the future despite their mental illness. However, this might not have been true for all the participants.

In spite of the positive findings, the participants' relapses were proof that there is a dire need for additional community-based resources to help MHC users recover after becoming ill and receiving a diagnosis. Although the group seemed to have benefited the members it should be supplemented by other community initiatives to meet the rehabilitative needs of service users. Programmes such as assisted employment, assisted living, follow-up home visits to track service users' recovery and community reintegration after being discharged from hospital, residential homes, and day-care services are but a few examples of ways to meet the rehabilitative needs of MHC service users.

In addition to the value the group had for the members, the experience also benefited me greatly as a psychology student. The initiative provided me with invaluable experience which bridged the gap between theory and practice. Based on my experience with the support group, I am of the opinion that psychology students in postgraduate training programmes can be utilised to facilitate support groups for MHC users at community-based clinics and health centres. I strongly feel that it is a viable way to supplement the human resource crisis in the MHC sector and offer additional resources to help meet the supportive needs of service users. Utilising students for the purpose of facilitating such groups offer the MHC service providers with additional service support while the students are afforded an opportunity to gain practical experience.

Strong collaborative partnerships between MHC service providers and student facilitators are crucial for the success of support group interventions. MHC service providers are in an ideal position to refer MHC users to the group and without their support recruitment might be challenging. Inviting group members who live within walking distance of the facilities helps greatly with regular group attendance which affects the sustainability of the group. It should be noted that the needs of MHC users are unique in every setting and a

needs analysis should be conducted with the group members to ensure that their unique needs are catered for.

I also noticed that not all MHC users might be interested in participating in support groups. I often wondered why so few displayed an interest in joining the group. There is no doubt a great need for more community-based MHC services. In order to ensure that the service users' needs are met, additional research is required.

5.3   Recommendations for Future Research

Although the qualitative findings from this research demonstrate the benefit the group yielded for the participants, one cannot necessarily generalise these findings to other settings. In order to determine if community-based support groups for MHC users will also benefit other service users, similar research will need to be conducted in other similar settings.

Moreover, the findings generated from this research did not measure the impact of the support group objectively. In order to determine if participation in a social support group intervention impacts positively on relieving symptoms, treatment adherence, and adjusting to community life, additional research is required.

The research highlighted that the participants are in need of additional services which could help them to rehabilitate and integrate into their community as contributing citizens. Despite the supportive benefits of participating in the support group, none of the participants was employed. This suggests that there is a need to determine the extent of additional assistance required to help MHC users adjust to life in their communities. Research which explores the rehabilitative needs of MHC users might help to identify the service gaps and

offer supportive evidence to advocate for additional services to meet the rehabilitative needs

as stipulated in the MHC Act.

In light of the relapses that occurred among the participants during the period after

data collection and the debriefing session, it might also be useful to explore relapse rates of

MHC out-patients in order to establish what precipitates relapse and which services might

assist with relapse prevention.

I have mentioned that the MHC service providers at the TDCHC were under

resourced and highlighted literature which supports the human resource crises in the MHC

sector. There is no doubt a need for additional human resources to meet the rehabilitative

needs of service users in community-based settings. Research exploring and determining the

needs of the service providers is also needed. In addition to this, exploring the needs of the

families of MHC service users to help them cope could also inform which services to

implement and develop.

5.4   The Study's Strengths and Limitations

In order to ensure the accuracy of the findings, I have employed multiple validity

strategies throughout the research process (Creswell, 2014). Such strategies comprised the

triangulation of two separate data sources to construct the final set of themes and sub-themes,

confirming the findings with the participants (member checking), declaring my personal bias

I brought into the research through offering reflexive accounts throughout the research report,

and spending prolonged time in the research setting (Creswell, 2014). I consider my

longstanding relationship with the research participants and the unique insider perspective

and familiarity with the context as the greatest research strength. My prolonged involvement

with the group and the research setting allowed me to develop an in-depth understanding of

the challenges MHC service providers at the TDCHC faced as well as the struggles and

difficulties the service users, and consequently their families, endured.

The qualitative approach allowed me to offer rich descriptive accounts of the

participants' experiences with the group. I feel this allowed me to illuminate the meaning

they ascribed to their group membership and highlight the value the group had for them.

Throughout this report I have reflected on the various measures to ensure the credibility of

the findings reflected here. I regard my efforts with which to ensure the accuracy of the

findings as another research strength and sincerely trust that I have made a convincing case

for the potential benefits of community-based support groups for MHC users.

I will by no means deny the positive bias that I brought to the study. I admit that I

might have leaned more towards reporting on positive aspects. I am aware that support group

initiatives are context specific and that it might not be successful in all community-based

clinics and health centres. However, based on the findings, I strongly believe that such

groups could be of value in other settings following a needs assessment to determine the

unique needs of service providers and service users.

The greatest limitation inherent in the qualitative research approach is that I cannot

offer any proof that the support group had a positive impact on the rehabilitation and

recovery of the MHC users involved in the group over the years. The findings only imply

that the participants' benefited from their group involvement. Another potential limitation is

that my involvement in the data collection procedures could have influenced the participants

to report on only the positive benefits.

Although I have made efforts to check the accuracy of the translations of the interview transcripts, meaning was potentially lost in translation. This might have impacted the richness of the findings and could be regarded as another limitation of the study.

5.5   Chapter Summary

This chapter concluded this report with my final reflections and remarks, recommendations for future research, and the study's strengths and limitations. A final reflection based on my experience with the group, I strongly believe that such groups can supplement the MHC system. I consider it a culturally appropriate service option which can assist the overburdened MHC service providers to meet some of the rehabilitative and supportive service demands of MHC users as advocated in the MHC legislation and policy guidelines within their respective communities. The main purpose of this research was to provide evidence for this and I trust that I have made a compelling case to support this claim. I further hope that this research will inspire more support group initiatives in other PHC facilities in community-based settings across South Africa.

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Appendix 1

Ethical Clearance Certificate

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Department of Psychology

14-11-2012

ETHICAL CLEARANCE OF A RESEARCH PROJECT INVOLVING HUMAN PARTICIPANTS

Project: Community based support groups: A social constructionist approach

Researcher: Ms. Leana Meiring

Supervisor: N. Themistocleous (Department of Psychology, Unisa)

The proposal was evaluated for adherence to appropriate standards in respect of ethics as required by the Psychology Department of Unisa.   The application was approved by our Ethics Committee without any conditions.

Letterhead2

Prof P Kruger

Department of Psychology
College of Human Sciences
University of South Africa

Appendix 2

Permission Letter

health and social development
Department: Health and Social Development
GAUTENG PROVINCE

Kuyasheshwa! Gauteng Working Better

427 Hilda Street, The Fields Building, Pretoria 0001 South Africa. Tel: +27 12 451 9000 Fax: +27 12 451 9125
Enquiries: Dr. K. E. Letebele-Hartell.
e-mail: Manel.Letebele@gauteng.gov.za

TSHWANE RESEARCH COMMITTEE

CLEARANCE CERTIFICATE

Meeting: N/A

PROJECT NUMBER: 11/2013

Title: Community based support groups: A social constructionist approach

Researcher: Ms. Leana Meiring
Co-Researcher:
Supervisor: Nicola Themistocleous
Department: The Department of Psychology, University of South Africa
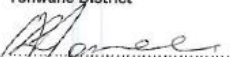
DECISION OF THE COMMITTEE

Approved

NB: THIS OFFICE REQUESTED A FULL REPORT ON THE OUTCOME OF THE RESEARCH DONE

Date: 22ⁿᵈ March 2013

Dr. K.E Letebele-Hartell
Chairperson Tshwane Research Committee
Tshwane District

Mrs. M Morewane
Director: District Health Services Support
Tshwane District

NOTE: Resubmission of the protocol by researcher(s) is required if there is departure from the protocol procedures as approved by the committee.

Appendix 3

Consent Forms

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Research participant informed consent form for the study entitled

Community based support groups: A social constructionist approach

Phase 1

Dear group member,

Thank you for agreeing to take part in this research and for offering us some of your time today. This research project is aimed at exploring the value of support groups at primary health care centres. In order to do this, we will be looking specifically at your support group at the mental health care clinic at this Tshwane District Community Health Centre (TDCHC). The purpose of the research is to find out what the group means to you to give evidence for the possible benefits and importance of future support groups in community health centres in your community. To do this we need your assistance. The data collection will take place in two phases.

Phase 1: Today we will engage in an interview with you, where we will be asking questions around your background, the group, and the meaning the group has for you.

Today's semi-structured interview will take up 60-90 minutes of your time and we ask your permission to voice record the conversation. If you agree to it, the interview will take place with the help of a translator to allow you to answer the questions in the language you are most familiar and comfortable with.

Phase 2: This phase will focus on collage making highlighting what the group means to you.

Participation in the research is completely voluntary, which means that you can decide if you want to take part in it or not. The advantage of taking part is that you will help us to give evidence for the possible benefits and importance of future support groups in community health centres in your community. There are no expected risks involved with participating in the research, however, should you have a need to discuss any issues that came up during your participation in the research, you will be able to speak to the psychologist.

We will treat your information with care and will not share it with anyone without your permission other than those who will assist with the transcription, analysis processes, and supervision. We will not use your names in the final report but will replace your name with pseudo-name so that no one will be able to identify you. The name of the CHC will also not be mentioned.

If you decide not to take part in the research activities you will not be penalized in any way and you may still be a member of the group. You are free to withdraw from the study at any time and if you decide to do so, your information will be destroyed if you ask us to do so.

This study has received written approval from the Research Ethics Committee of the College of Human Sciences, Unisa and from the Department of Health. A copy of the approvals letter can be obtained from the researcher if you so wish.

If you want to know more about the research, you are welcome to ask me (Leana) or contact me on 079 1920 220. The information from the study will be stored at the University of South Africa for 15 years but it will be kept confidential and will not mention your names.

Consent to participate in this study

I, _____ (participant's name), confirm that the purpose, the aims of the research and the research process have been explained to me. I also confirm that the nature, procedure, potential benefits and anticipated inconvenience of participation have also been explained to me.

I understand that all my information will be kept confidential.

I have read (or had explained to me) and understand the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty.

I am aware that the findings of this study will be anonymously processed into a research report, journal publications and/or conference proceedings.

I agree to the recording of the semi-structured interview.

I have received a signed copy of the informed consent agreement.

Participant's name & surname.. (please print)

Participant's signature..Date......................

Researcher's name & surname.. (please print)

Researcher's signature..Date......................

Witness' name & surname.. (please print)

Witness' signature..Date........................

Declaration of Mental Health Care Practitioner

I, _____ (name, surname, and position at CHC)
hereby declare that the above participant is currently not displaying any active symptomatology
and is able to participate in the above study. I am satisfied that the participant understands the
information in this form and provided full informed consent.

MHC practitioner's signature...Date........................

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Research participant informed consent form for the study entitled

Community based support groups: A social constructionist approach

Phase 2

Dear group member,

Thank you again for agreeing to take part in this research and for offering us some of your time. As mentioned in the previous phase this research project is aimed at exploring the value of support groups at primary health care centres.

Today we are asking your permission to participate in the second phase of the research on the support group in the mental health care clinic at this Tshwane District Community Health Centre (TDCHC). The purpose of the research is to find out what the group means to you and to give evidence for the possible benefits and importance of future support groups in community health centres in your community.

Today we are asking you to make a collage of the group and what the group means to you with the use of pictures. You will be asked to make your own individual collage. After completing your collage we want you to then tell us a story of the pictures you have used in the collage. We will also ask some questions about your collage. Today's activity and interview will take up more of your time. Each group member will tell their individual story and the rest will be asked to wait. If we do not finish today we will ask you if you could please come back another day. The interviews will take up about 60 minutes of your time and we ask your permission to voice record the conversation. If you agree to it, the interview will take place with the help of a translator to allow you to answer the questions in the language you are most familiar and comfortable with.

Participation in the research is completely voluntary, which means that you can decide if you want to take part in it or not. The advantage of taking part is that you will help us to give evidence for the possible benefits and importance of future support groups in community health centres in your community. There are no expected risks involved with participating in the research, however, should you have a need to discuss any issues that came up during your participation in the research, you will be able to speak to the psychologist.

We will treat your information with care and will not share it with anyone without your permission other than those who will assist with the transcription, analysis processes, and supervision. We will not use your names in the final report but will replace your name with pseudo-name so that no one will be able to identify you. The name of the CHC will also not be mentioned.

If you decide not to take part in today's research activities you will not be penalized in any way and you may still be a member of the group. You are free to withdraw from the study at any time and if you decide to do so, your information will be destroyed if you ask us to do so.

This study has received written approval from the Research Ethics Committee of the College of Human Sciences, Unisa and from the Department of Health. A copy of the approvals letter can be obtained from the researcher if you so wish.

If you want to know more about the research, you are welcome to ask me (Leana) or contact me on 079 1920 220. The information from the study will be stored at the University of South Africa for 15 years but it will be kept confidential and will not mention your names.

Consent to participate in this study

I, _____ (participant's name), confirm that the researcher has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I understand that all my information will be kept confidential.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty.

I am aware that the findings of this study will be anonymously processed into a research report, journal publications and/or conference proceedings.

I agree to the recording of the semi-structured interview.

I have received a signed copy of the informed consent agreement.

Participant's name & surname.. (please print)

Participant's signature...Date.....................

Researcher's name & surname.. (please print)

Researcher's signature...Date.....................

Witness' name & surname.. (please print)

Witness' signature...Date.........................

Declaration of Mental Health Care Practitioner

I, _____ (name, surname, and position at CHC) hereby declare that the above participant is currently not experiencing any active symptomatology and is able to participate in today's research activities. I am satisfied that the participant understands the information in this form and provided full informed consent.

MHC practitioner's signature...Date.......................

Appendix 4

Interview Schedule

Phase 1 Semi-structured Interview Schedule

General

       Name of translator:
       Date:
       Consent obtained:
       Asymptomatic:
       Beginning time:
       Completion time:

Biographical information

1. Name of interviewee
2. Age
3. Culture/Ethnicity
4. Home language
5. Highest level of education
6. Are you on disability grant?
7. Family's monthly income

Background

8. Can you tell me what mental illness you have?
   - Why do you come to the clinic?
   - What are you being treated for here?
9. When did you join the group?
10. How did you come to know of the group?
11. Why did you decide to join the group

Group experience and meaning

12. Tell me your story of being involved in the group, beginning when you first heard about the group
    (To learn about their experiences and meaning the group has for them)
13. What have you learned from being in the group?
14. How is your life different since you have joined the group?
    - I have noticed big changes in how you are in the group since I first met you, do you feel that you have change in any way from being in the group?
15. What made you come back to the group every time?
    (commitment)
16. Why do you think the group has lasted so long, while groups in other clinics did not last so long?

17. Tell me what you think is good about the group
18. Tell me what you think is not good about the group
19. How would you like the group to be better?
20. How would you feel if the group ends?
21. Is there anything else you would like to share before we end?

End

Appendix 5

Reflexive notes: Debriefing session

Member checking and debriefing session: 19 August 2015

I arranged a debriefing and member checking session with the research participants to allow them an opportunity to comment on the findings and reflect on their participation in the research process. It was an informal session and it was not voice recorded. All those present signed an attendance register to recode who attended the session.

I invited one of the 2015 student group facilitators along to act as the translator in order to ensure that all the participants understood what was said. Only three of the five members were able to attend. I could not reach Participant 4 on the number I had for her. I sent a message to her son's phone but she did not show up for the session. The other participants and the group facilitator told me that she had been absent from group sessions for the past three weeks. I managed to get hold of Participant 2's wife and she told me that he would not be able to attend the session due to his recent relapse. She explained that he was at a place of recovery in another community.

Only Participant 1 was on time for the session. Participants 3 and 5 only showed up after the session with Participant 1 and we did another session with them. I explained that the purpose of the session was to share the themes with them to ask if they agreed with what I had constructed. I explained that the themes were created by reading their interview transcripts and that the meaning was co-created between me as the researcher and them as the participants. I explained that their stories were written up to show how the group has benefited them. I explained that it was my hope that the research would encourage The

Department of Health to support more such initiatives. They were very pleased to hear that their stories could possibly help others like them.

Firstly I read their biographies to them and allowed them the opportunity to confirm whether all the information was accurate and correct and if they allowed me permission to share their background information. I explained that their identities were protected by not mentioning their names, the name of the Community Health Centre, or the name of their community. Only Participant 5 added that he also did ABET education in 2008 and that he was referred to the group by the psychologist. Participant 1 and 3 were happy with their biographies and all three participants granted me permission to share the information.

Next I explained the main themes. I explained that the purpose of the research was to find out what the group meant to them and that I came up with five ideas based on the information they had shared during both phases of the data collection interviews. Each theme was explained to them one by one. The translator explained the information in the local dialect. All the participants agreed with the themes and said that they felt everything was true and accurate.

Based on their feedback I am confident that they agreed with the themes I constructed. I was finally satisfied that the themes represented a true co-creation of meaning between myself and the participants. In response to Theme 5, Participant 3 said that he felt there was no hope any more. He did however agree that the group benefited him in many ways. This was again an indication that Mental Health Care users are in need of more support services to help them cope with the multitude of challenges of living with severe and chronic mental illness.

Participant 1 mentioned that he told the truth during his interviews. Hearing this gave me some reassurance that the information they shared was authentic. In conclusion, I thanked the participants for taking part in the research and for sharing their stories. They all reported that it was a positive experience. Participant 5 added that the group taught him things he did not know about himself and Participant 1 also said that he enjoyed being interviewed.

After the session, I asked the student group facilitator to share her feedback on the debriefing. She agreed that the participants all seemed to be in agreement with the themes and that it is safe to assume that the meaning the participants ascribed to their group membership was accurately reflected in the themes presented in the final report.

Appendix 6

Language editing certificate

Pat Finlay
English Language Editing

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P O Box 7118, Greenstone, 1616.
Cell: +27 (0)83 320 7951
Fax: 086 6111 643 (South Africa only)

30th October 2015

TO WHOM IT MAY CONCERN

This is to certify that I, a native English language speaker, have edited the thesis, COMMUNITY-BASED SUPPORT GROUPS FOR MENTAL HEALTH CARE USERS: A SOCIAL CONSTRUCTIONIST APPROACH, by Leana Meiring, for English style, language, and consistency.

The responsibility to accept or reject suggestions rests with the student.

Thank you for the opportunity to do this.

Sincerely

P J Finlay

Patricia-Anne Joy Finlay

Full member of the Professional Editors Group