Factors Affecting Attendance and Participation in Group Therapy in a Private Inpatient Psychiatric Setting

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Declarations

Unless specifically stated to the contrary in the text, this dissertation is the original work of the undersigned.

_____   <u>26 November 2015</u>

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I hereby declare that this dissertation has been submitted for examination purposes with/~~without~~ my consent.

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Abstract

This study seeks to understand why many patients did not participate in a group therapy programme offered at an inpatient psychiatric hospital in Pietermaritzburg, South Africa. Conducted by an Occupational Therapist, the study analyses a sample of inpatients' perspectives, gathered via semi-structured interviews, of the factors that affect group therapy attendance and participation. The data was analysed qualitatively using thematic analysis. The results suggested that positive experiences and therapeutic outcomes, renewed hope and the helpful, supportive and non-judgemental nature of the group *encouraged* group therapy attendance and participation. These factors mirrored many of Yalom's (2005) therapeutic factors. The following factors were found to *hinder* group therapy attendance: stigma, shame, a belief in the negative stereotypical portrayals of mental illness, physical pain, fatigue and negative side effects of medication. The findings were used to generate recommendations which could potentially be applied over a variety of clinical settings in order to increase group therapy attendance and participation and also enhance the therapeutic experience of the inpatient with a psychiatric illness.

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Chapter 1: Introduction

1.1 Introduction to the Problem

"No one is unique; there is no human deed or thought that is fully outside the experience of other people."

-Irvin Yalom (2005, p. 72)

After working in both the private and government sectors of inpatient psychiatry, the researcher noticed a trend emerging in the reluctance of patients to attend group therapy sessions. When trying to understand this behaviour she questioned if it could be due to their fear of the unknown or was it rather the lethargy and apathy so often associated with psychiatric conditions? Or was it perhaps the general health complaints often associated with psychiatric conditions e.g. headaches, fatigue, body pain, nausea etc. that were limiting their group therapy attendance? In order to fully understand inpatient psychiatric patient adherence at a particular study site and with this knowledge to promote greater adherence for these patients, the researcher decided to explore this conundrum further and hence this study was born.

Group therapy as a treatment modality has been shown to have many far reaching benefits to a broad spectrum of patients with mental illness (Burlingame, MacKenzie & Strauss, 2004; Kosters, Burlingame, Nachtigall & Strauss, 2006; Page & Hooke, 2009; Silverberg, 2010; Yalom, 2005).

McDermut, Miller and Brown (2001) in their meta-analysis on the effectiveness of group therapy found that 94% of the studies concluded that group therapy was an effective treatment modality for reducing the symptoms associated with psychiatric illnesses.

A few years later, a further meta-analysis by Burlingame, Mackenzie & Strauss (2004) found that group therapy is effective at lessening psychiatric symptoms whether it is the major component of treatment or whether it is used as an adjunct to individual therapy. The study also showed that the most effective and successful groups have a common identity and a shared sense of purpose which encourages the psychological wellbeing and recovery of the group participant (Burlingame et al, 2004). According to Yalom (2005) when a patient hears feedback from their peers, or fellow inpatients, this guidance may be interpreted as more effective than that from the therapist as peers relate more easily to one another. Those peer interactions and internalisation of the feedback by the participant seem to translate into real world gains.

Looking at the above, one would assume that the majority of patients would be motivated to attend group therapy; however research begs to differ (Morris & Schulz, 1992). A recent review by Lefforge, Donohue and Strada (2007) studied the attendance of substance abusers to group therapy sessions and their results indicated that between 10% and 60% of sessions are not attended. The extent to which a person's behaviour coincides with medical or health advice is increasingly being recognised as a major consideration in the daily management of patients in a variety of international health care settings and in the attainment of therapeutic goals (Cameron, 1996). Research into treatment non-adherence

has risen hugely as an increasing number of patients are choosing not to comply with therapeutic recommendations (Morris & Schulz, 1992). Non-adherence has direct implications for the health of the patient, the effective use of resources and the assessments of the clinical efficacy of treatments (Playle & Keeley, 1998). Given the information above, this study aims to investigate the factors affecting attendance and participation in group therapy in a private inpatient psychiatric setting. In this chapter the reader will gain a clearer understanding of the core basis for this study. This will include the explanation of aims and objectives as well as the broader significance of the impact that the study plans to have. All terms will be explained and the outline for the direction of the study, clarified.

1.2 Background and Rationale of the Problem

As mentioned previously, psychiatric patients often do not utilise the group therapy treatment that is available to them. This poor adherence results in the patients missing out on the potential benefits of attending the sessions. Patient adherence is a crucial factor to the efficacy of therapeutic programmes and regimens (Vermeire, Hearnshaw, van Rooyen & Denekans, 2001). This poor adherence is not limited to psychiatric populations evidenced by WHO (World Health Organisation) in 2003 estimated that only 50% of patients suffering from chronic cardio-vascular disease in developed countries, follow treatment recommendations. Non-adherence was found to be due to 1.) Issues relating to the patient e.g. suboptimal health literacy, lack of involvement in treatment decision-making process, 2.) Issues relating to the physician e.g. complex regimen prescription, communication barrier, ineffective communication about

side-effects and 3.) Those related to the health care system e.g. time allocations, limited access to care and lack of health information technology.

After decades of adherence research and multitudes of theories to try to explain the behaviour of non-adherence, very little comprehensive or conclusive information appears to be available (Morris & Schulz, 1992). Donovan and Blake (1992) maintain that at least one third, comparatively less than the WHO study (2003), of physically or mentally ill patients will fail to comply with medical treatment and therapeutic advice even if it is within their best interests to follow this advice. Adherence research, in a variety of medical fields, has mostly been dominated by the health professionals' opinions and perspectives, with little regard being given to the patient's perspective and opinions (Morris & Schulz, 1992). There is therefore a need to examine a small section of adherence behaviour by investigating adherence to group therapy from the perspective of the patient with a psychiatric illness and to incorporate their beliefs and attitudes into understanding their lived experiences, which is the core of the current study.

1.3 Problem Statement

Based on the above discussion, a significant problem is evident that poor group therapy attendance of psychiatric patients may negatively affect their possible treatment gains and there is little research available on the patient's perspective and opinions to understand this treatment non-adherence.

1.4 Research Question

These problems lead to a number of possible broad research questions: What are the specific factors that are contributing to a patient's adherence behaviour? What motivates a patient to want to attend the group therapy sessions? What factors hinder this attendance? Does it have an impact on a patient's attendance if their significant others (family, friends and health care professionals) encourage or discourage attendance? When a patient is 'expected' to attend groups as at the study site, does this affect their attendance?

1.5 Aims and Objectives

1.5.1 Aim of the Study

The study aims to describe and analyse the main factors that contribute to patient's adherence or non-adherence behaviour, specifically relating to inpatient group therapy programmes from the perspective of patients themselves. Further to this, the study aims to discover people's personal experiences within a group session and what motivates them to keep attending/not attending the group sessions that are available to them. With this knowledge, the researcher aims to identify methods to improve patients' attendance and enhance their overall recovery.

1.5.2 Objectives of the Study

- To study patients' attitudes, opinions and perceptions of group therapy as an effective or non-effective treatment modality.

- To identify the patients' perspectives of the positive and/or negative consequences or outcomes that have resulted from attending/not attending the group therapy programme.

- To determine the factors that motivates and/or hinders patients in their attendance and participation in group therapy.

- To generate or review methods for enhancing group therapy attendance and participation within the inpatient psychiatric setting.

- To ascertain patients' perceptions of the social support that they receive from significant others (doctors, psychologists, family, friends etc.) regarding the attendance of group therapy.

1.6 Type of Study and Method

In order to meet these objectives the research study adopts a qualitative design as it is the most appropriate method to explore the meaning and promote deeper understanding into the participants' personal experiences of group therapy. To this end, the researcher will be using semi-structured individual interviews as the primary method of data collection.

According to Silverman (1993), qualitative research is based on conventional methodology which assumes that social perspective is not a factual reality that exists outside of 'us' but rather a process that we reconstruct everyday by our acts. These acts lead to experiences that we are then able to bear witness to and report upon. This study aims to analyse and interpret the personal experiences reported upon by patients of their own group therapy experiences.

Based on the constructs of interpretive epistemology, the focus is thus on the understandings and interpretations of individuals rather than an attempt to control or define their perspectives. Understandings and interpretations are foremost concepts in all qualitative research based on conventional methodology. The aim of conventional methodology in this study is to find out the point of view of the research subjects rather than that of objectivity and generalisation used in many quantitative research designs (Silverman, 1993).

The study did gather some quantitative data on group attendance and demographic variables of participants which allowed a quantitative analysis of any possible relationships between group attendance and demographic variables. This analysis was briefly included as an add on to the main study to see if any interesting relationships emerged.

1.7 Significance of the Study

The researcher intends to arrive at a workable solution aimed at enhancing the attendance and participation of inpatients with psychiatric illness to a group therapy programme, in order to improve their treatment outcomes. Using the knowledge and the understanding gained from the study, a programme or intervention model may be designed aimed at enhancing group therapy attendance and participation among the target population. Should this model be successful then replication would be encouraged throughout inpatient psychiatric settings.

1.8 Outline of Study

The remainder of this document will highlight all key factors as well as incorporating knowledge gained from the literature review to apply to the research method, data collection and analysis. The literature review discusses the 'costs' of the psychiatric admission as well the direct benefits to the patients that do attend group sessions related to the dose-response model. Adherence behaviour is covered in detail as well as research into health seeking behaviours. The model according to Yalom (2005) is the main focus for the discussion on the effectiveness of group therapy and the study by Ruane (2010) remains the most applicable South African study to this research theme. This study also highlights the severe lack of research into group therapy adherence within the South African inpatient population. These will be further examined and explained; results will be presented to reach the discussions and conclusions in the latter part of the study.

1.9 Summary

The chapter above highlights the core of the research study and the basis of knowledge that the researcher has used to reach a decision to initiate a research study on this subject. The chapter provides the reader with a clear direction for the study as well as the aims and objectives of the study and serves as the foundation for the starting point of investigation into the factors affecting patient's attendance and participation in group therapy programmes.

Chapter 2: Literature Review

2.1 Introduction

The following literature review details an intricate course of study through the path of adherence behaviour, the effect of psychiatric admissions as well as how and why group therapy works. The review highlights the direct benefits to the patient, barriers to health seeking behaviour and concludes with an evaluation of group therapy adherence research within the South African context and highlights the need for additional work in this area.

Initially, the studies on the effectiveness of group therapy are reviewed in order to determine whether the literature supports group therapy as an effective modality for the treatment of the patient with psychiatric illness. Thereafter the benefits of group therapy according to various diagnoses are examined and the link between the amount of group therapy attendance is directly linked to sustained health and wellbeing through the dose-response model (Howard, Kopta, Krause and Orlinsky, 1986). The focus then moves to the specific and direct benefits of group therapy attendance by critically analysing the theories and therapeutic factors according to Yalom (2005) and is discussed with supporting research findings as well as those that criticise the findings of Yalom.

Research into the determinants of patient attendance to group therapy is discussed as well as the hindering and motivating factors addressed while reviewing a number of theories as an attempt to understand health behaviour further. Group therapy in Occupational Therapy is explored and the review closes with highlighting the lack of

research into this theme and more specifically within the context of South African group therapy.

2.2 Definition of Key Concepts

The following terms are used multiple times during this study, in order to ensure clarity, they are detailed below:

'*Adherence*' is defined by the extent to which a patient continues with previously agreed-upon treatment behaviours under limited or no supervision even when faced with conflicting demands (Merriam-Webster Medical Dictionary, 2011). In the context of the study, when a patient enters the clinic, they agree to adhere to the group therapy programme offered. In this study, the attendees did adhere to this agreement however the non-attendees did not.

'*Attendance*' is defined by the Oxford Dictionary (2000) as the action or state of going regularly or being present at a place or event. In this study the place of attendance is the group therapy session room and the event is group therapy.

'*Factors*' is defined as a circumstance, fact, or influence that contributes to a result (Oxford Dictionary, 2000). In this study, the factors are any influences that could hinder or motivate a patient to attend a group therapy session.

Global Assessment of Function (GAF), is a numeric scale ranging from 1 to 100 used by mental health professionals to subjectively rate the social, occupational, and

psychological functioning of an adult presenting with a psychiatric complaint as according to The Diagnostic and Statistical Manual IV (American Psychiatric Association, 2000)

'*Group Therapy*', according to Yalom (2005), is defined as a form of therapy in which a small group of selected individuals meet with a therapist to assist each other in emotional growth, learning and personal problem solving. DeMare and Kreeger (1974), explain that Occupational Therapy groups can be divided into three categories namely; psychotherapeutic, communicational or recreational and that the therapist achieves these by an activity/task group, a social group or a combination of the two.

'*Health Care Professional*' is defined within the South African context as a suitably qualified professional who provides a service and is registered with an appropriate regulatory board e.g. The Health Professions Council of South Africa (HPCSA). In this study, the health care professionals are also the professionals/group therapists that provide the group therapy sessions namely; counselling psychologists, clinical psychologists, nurses and occupational therapists.

'*Health Seeking Behaviour*' is defined as the personal action and decisions to promote optimal wellness, recovery and rehabilitation (Merriam-Webster Medical Dictionary, 2011). In this study it is the decision whereby a patient decides to attend the group sessions in order to optimise their rehabilitation and recovery.

'**Participation**' in Oxford Dictionary (2000) is taking part or being actively involved in something i.e. actively engaging in the group therapy process.

The '**Private Psychiatric Setting**' in this study refers to the study site which was a Private Psychiatric Clinic in Pietermaritzburg, KwaZulu-Natal, South Africa.

'**Psychiatric Illness**', '**Psychiatric Condition**' or '**Mental Illness**' refers to a broad category of disorders characterised by dysregulation of mood, thought and/or behaviour as according to the Diagnostic and Statistical Manual IV (American Psychiatric Association, 2000.

2.3 Literature Review

2.3.1 Studies on the Effectiveness of Group Therapy

In their study titled, 'Is Group Therapy effective at Treating Depression?' McDermut, Miller and Brown (2001) performed a meta-analysis of 48 studies on group therapy effectiveness. Their meta-analysis found that 45 of the 48 studies concluded that group therapy was effective at reducing depressive symptoms with 43 of these showing statistical significance of these benefits.

With reference to the above, as well as various other researchers findings (Burlingame et al, 2004; Kosters, Burlingame, Nachtigall & Strauss, 2006; Page & Hooke, 2009; Silverberg, 2010; Yalom, 2005), it is clear that group therapy is an effective and successful treatment modality for addressing the nature of the

psychiatric condition and the chosen therapeutic medium of many professionals. In some instances, group therapy has been proven to yield even better results than that of individual therapy (Yalom, 2005). The discussion will now explore the specific factors that may create the benefits that many of the above and other studies have suggested.

2.3.2 Benefits of Attending Group Therapy

Lorentzen, Ruud, Fjeldstad & Høglend (2013), studied the effectiveness and outcomes of short-term and long-term group therapy on patients diagnosed with mood, anxiety and personality disorders. Patients exposed to both short term and long term group therapy made significant gains in terms of the experience of psychiatric symptoms, interpersonal problems and Global Assessment of Functioning (GAF).

In 1996, Budman, Demby, Soldz and Merry performed a study on the benefits of group therapy to patients diagnosed with personality disorders. According to their results, patients reported substantial improvements in self-esteem, symptomatology, and diagnosability on Axis II of the DSM-IV (APA, 2000). According to their results, group treatment appears to be a hugely promising mode of intervention for those patients with personality disorders.

Page and Hooke (2009) evaluated 2782 inpatients with psychiatric diagnoses during a year-long period. The study was based at a private psychiatric clinic in Australia and their research revealed that with the encouragement to attend group sessions by the nursing and support staff that patient's group attendance doubled. However the remarkable outcome of this was that the need for readmission six months to a year later was halved. This study highlighted the possible link between group attendance

and successful sustained health of the patient with psychiatric illness. Furthermore an emerging best practice guideline (Page & Hooke, 2009) was established that noted that by increasing the amount of group therapy sessions attended that this increased the positive patient outcomes too. The result is consistent with the dose-response model of psychotherapy. This model was most recently highlighted by Howard, Kopta, Krause and Orlinsky (1986) who proposed that the dose-effect/dose-response model (borrowed from Pharmacology) which directly links the amount or dosage of individual therapy sessions attended, to the improvement that patients experience as a result of attending these sessions. Most other dose-effect literature focussed more on individual therapy sessions, however in 2006, Ghebremichael, Hansen, Zhang and Sikkema adopted the dose-response model and applied it to group therapy. Their study focussed on bereaved HIV positive individuals with experiences of grief and psychiatric distress. The results from the study suggest that a dose-response relationship exists where 'dosage' was defined as the number of group treatment sessions attended and the 'effect' was based predominantly on clinician ratings of patients improvement post-exposure. Results therefore concluded that both grief and psychiatric distress were inversely related to dosage, indicating that the higher the intervention exposure, the greater the reduction in grief and distress symptoms.

Within the current South African context, inpatient psychiatric admissions are financially costly to the individual and the economy (Page & Hooke, 2009). Loss of income has a direct effect on the person and their dependants as well as the impact that the economy suffers due to the absenteeism of employees. Personally, a hospital admission can be disruptive to patients as they temporarily disengage from their primary social roles of parent, caregiver, child etc. Therefore, it is of utmost

importance that during their admission a patient receives optimal treatment so that the need for future admissions and treatment is reduced. Additionally group therapy is also a cost effective treatment as it enables a single healthcare provider to treat multiple patients simultaneously.

2.3.3 Direct Benefits to the Patient of Attending Group Therapy Sessions

Irvin Yalom, Emeritus Professor of Psychiatry at Stanford University has dedicated his life to understanding and studying Group Therapy and Existentialism and has published many articles and books as to why and how group therapy is effective. Yalom gleaned his theories from a detailed review of literature as well as several decades of clinical experience. According to Yalom (2005) group therapy provides patients with a safe therapeutic environment where they are contained and encouraged to explore some of their issues and problems while integrated into an interpersonal dynamic. After many years of research into the field of Group Therapy, Yalom (2005) identified eleven curative factors, later renamed as 'the therapeutic factors' defined as 'the actual mechanisms of effecting change in the patient during the group process' (p. xi). These therapeutic factors include: instillation of hope, universality, imparting of information, altruism, corrective recapitulation of the primary family group, development of socialising techniques, imitative behaviour, interpersonal learning, group cohesiveness, catharsis and existential factors. The therapeutic factors are described and discussed below:

Instillation of hope refers to the importance of ensuring that a patient who enters into group therapy can begin to explore the possibility that all is not lost. Attention is drawn to allowing the patient to witness the success and 'hopefulness' of some of the other group members. This emphasises the idea that the patient needs to reach

a place where they feel that change is possible and that there is hope, where after the other therapeutic factors can begin to take effect. Dufault and Martocchio (1985) defined hope as, 'a multidimensional dynamic life force characterised by a confident yet uncertain expectation of achieving future good which, to the hoping person, is realistically possible and personally significant' (p.380). According to Herth (2000) hope theories enjoy considerable theoretical and empirical evidence and support in all areas of therapy. However a meta-analysis performed by Weis and Speridakos (2011), found that only modest evidence exists for the ability of hope enhancement strategies to increase life satisfaction. Furthermore their research showed no consistent evidence that these strategies alone can alleviate psychological distress.

Universality helps a patient to feel that they are not alone in their suffering nor are their psychological difficulties or experiences completely unique. When a patient enters into a group setting they often feel alone, afraid and shameful. Just seeing and listening to others' experiences can in itself be a healing process through a normalisation experience. As a group member begins to settle into the session, they realise that the other members accept them and are not judging what they have to say or have experienced. Shame and isolation begin to fall away. Also knowing that there is universality and connectedness of human emotion and experience provides a greater sense of understanding and healing.

Yalom's next factor is the *imparting of information*, or otherwise known as psychoeducation. During this process the group therapist uses didactic instruction to inform the patient of the illness process, healthy coping mechanisms and maladaptive patterns of behaviour as a way of developing the patients' insight into their own lives through reality checking.

A further therapeutic factor is *altruism* which is the act of giving without expecting anything in return. Within the group therapy process, an individual 'gives' advice or encouragement to another member without expecting a return or reply, thus demonstrating an altruistic act. Through this practice, the individual also develops a sense of worth in being able to be of value and importance to another. When we are supporting others, it gives us time to create space away from and perspective into our own problems.

The next therapeutic factor described by Yalom (2005) is the *corrective recapitulation of the primary family group*. According to Yalom (2005) many of the patients seeking help for psychiatric conditions have encountered difficult experiences in their first and most important group – their family of origin. Due to the group resembling a family in many ways in terms of the presence of parental figures, sibling/peer figures, conflict, intimacy and deep emotion, this allows the patient the opportunity to correctively relive, understand and repair early family dynamics and conflicts.

The *development of socialising techniques* is one of the therapeutic factors that presents in most group therapy sessions. Through group interactions, patients learn social skills as they process their own emotions, resolve conflict with others and become more aware and less judgemental of others. By expressing empathy and allowing the group to provide feedback to the individual, many insights are developed that can be applied to the patient's relationships outside of the group setting.

Imitative behaviour is the modelling of another's behaviour. Within the group context, a patient may 'try out' the behaviour that they have seen from other group members

or the therapist leading the group. Through this, the patient is able to identify who and what they are and who and what they are not. When experimenting with behaviour, the patient may learn new and possibly better ways of managing their stressors in the outside world.

Time and time again in his literature, Yalom (2005) mentions the notion that the group is a social microcosm of the member's real-world lives and much importance is placed on the process of *interpersonal learning*. He goes on to say that an individual cannot transcend the need for human contact and that this individual has to be seen within the matrix of their interpersonal relationships. Therefore during the group process, patients unconsciously are always learning and gaining new insights from others. Members also experience intense corrective emotional experiences when expressing their emotions and taking risks in a supportive and secure environment. This encourages more genuine and honest interactions in the group session and is then carried through to their own interpersonal relationship outside of the group setting.

Group cohesiveness is the unity within the group that allows a member to feel a sense of warmth and belonging within a safe and comforting environment. The participants value the group and feel valued and unconditionally accepted by others. This fills the basic human desire of feeling like they belong somewhere and is an extremely important process in order for the group as a whole to feel safe enough to venture into difficult and emotional territory. Venturing into this area develops as members self-disclose and begin to explore themselves personally due to feeling that they are secure and 'together' with the group. There is a general consensus in the literature that cohesiveness promotes positive outcomes in group therapy sessions and is integrally related to the success of group therapy (Burlingame,

Fuhriman, & Johnson, 2002). Higher levels of cohesiveness as well as an increase in cohesiveness over the lifespan of the group seem to be associated with a reduction in symptom distress and an improvement in interpersonal functioning (Burlingame et al, 2002). However, Hornsey, Dwyer and Oei (2007) argue that the empirical evidence for the centrality of cohesiveness is limited. They highlighted three interrelated problems with cohesiveness: 1) research suggests poor consensus on the definition of concept where it is described very vaguely, 2) inconsistent measurement of cohesiveness and 3) lack of attention to the mediators of cohesiveness-outcomes relationship. The authors argue that cohesiveness is too amorphous to be useful as a therapeutic construct and that the field of group therapy could benefit by identifying more specific group processes that facilitate or impede positive outcomes.

A further therapeutic factor is *catharsis* which is the process whereby an individual releases deep emotional experiences and pain and is able to feel relief and bring about personal healing through this release. The group therapy process facilitates the awareness of repressed emotions and allows the individual to feel securely 'held' within the group to be able explore these. Provided there is good group cohesiveness, the group member can experience powerful cathartic release as the other group members support the discussion of the intense emotional experiences, thereby growing in their own emotional understanding.

Existentialism is the psychological and philosophical construct that life is unfair and unjust at times, that there is no escape from human pain, that no matter how close we may become to other individuals that we are ultimately alone and lastly that there is no escape from the inevitability of our own death and the deaths of others. Once an individual is able to come to terms with this, they are able to live more freely and

fully while being more present in the here and now and worrying less about the little things. 'Existential factors' also incorporates the process whereby the individual takes complete responsibility for how they live their lives no matter what happens to them or the amount of guidance that they receive from others.

To varying degrees, many of Yalom's therapeutic factors are likely to be relevant to all models of group therapy. However, there have been some criticisms of Yalom's therapeutic factors, Butler and Fuhriman (1983) found that Yalom's theories on therapeutic factors were severely limited as they relied solely on patient's self-reports and showed little behavioural evidence as to the outcomes of these factors. Furthermore, they criticised the fact that although named 'therapeutic factors' that there is in fact very little research to support the relationship between these factors and therapeutic outcomes. Crouch, Bloch and Wanlass (1994) have also criticised Yalom's theories of therapeutic factors saying that they were unbalanced in their content and overlapping in their themes.

2.3.4 Attendance and Participation in Group Therapy

Given the research suggesting the effectiveness of group therapy, one may assume that patients would be keen and motivated to participate in groups. Unfortunately, this is often not the case as many patients resist engaging in group therapy. Research suggests that a number of factors may influence group attendance which will briefly be reviewed.

Ilardi and Kaslow (2009) hypothesised that social and relational factors are associated with lower group therapy attendance in abused, suicidal, and low-income African American women. Results indicated that lower attendance was related to

maladaptive attachment styles, particularly pertaining to the fearful type. In addition, interpersonal difficulties, including perceived social differences, lack of social acceptability, and social victimisation were predictors of the women's participation in the group therapy programme. Contrary to their initial predictions however, perceived social support from friends and family was not seen as a significant predictor of group therapy attendance. Although both attachment style and interpersonal difficulties were independently predictive of group therapy attendance and participation, attachment style was the strongest independent predictor.

More recently in 2010, Silverberg's findings indicated that increasing attendance and participation in inpatient group therapy sessions would help in providing more positive outcomes for the patient upon discharge into their communities. Interestingly, in her research paper titled, 'Inpatient Group Therapy: Predicting Attendance and Participation' (Silverberg, 2010), the results showed that the following characteristics of patients were not associated with their attendance and participation in group therapy while hospitalised: age, marital status, ethnicity, gender, socio-economic status, suicidal or homicidal ideation, psychosis, length of admission, history of prior admissions, Global Assessment of Function (GAF), substance abuse history and type of medication currently being taken. The results of the analysis also indicated that there is a relationship between group leader credentials and attendance and participation in therapy groups. Furthermore, she discovered that there was no conclusive evidence to suggest that the topic of the group being presented has any relevance to the attendance or participation of the inpatients.

According to Cameron (1996), the social and psychological factors thought to influence adherence behaviour are knowledge and understanding between patient and provider, patient satisfaction, open communication, social support, health beliefs, attitudes and factors associated with the particular diagnosis. For example, avoidance, withdrawal and isolation are symptoms of a number of psychiatric disorders which would obviously affect patient's attendance and participation in group therapy in this study and need to be taken into consideration.

In 2010, Gulliver, Griffiths and Christensen (2010) in their study of the barriers and facilitators of health seeking behaviours in young people found that stigma and embarrassment, problems identifying mental health symptoms and the preference for self-reliance led to many people choosing not to seek professional assistance for their psychiatric conditions. Although the study site is a psychiatric inpatient hospital, many of these barriers such as stigma, embarrassment, fear and the preference for self-reliance still exist and can be applied to the inpatient psychiatric patient and their relationship to the attendance to the group therapy programme. The evidence was less clear about the facilitators to health seeking behaviour and the study found that previously positive experiences as well as encouragement and support led to participants being more likely to seek help. It appears that this may be applicable within the group therapy context.

Within the South African context, very little research into patient adherence has been done and even less specifically looking into the health behaviours of patients regarding group therapy. In her research titled Obstacles to the Utilisation of Psychological Resources in South Africa, Ruane (2010) found that cultural beliefs, the stigma of mental illness, insufficient knowledge on signs and symptoms of mental illness and lack of awareness of resources available to them, were the main barriers

to people seeking psychological assistance. Further exploration into South African literature revealed very little applicable research to this study, in this regard, further research into the study of the factors affecting patient's participation in group therapy is thus deemed imperative to the further understanding of this theme.

2.3.5 Group Therapy in Occupational Therapy

The use of therapeutic group work remains a fundamental part of occupational therapy practice in the acute mental health setting (Cole, 2008). Finlay (2004) in her book 'The Practice of Psychosocial Occupational Therapy' places great emphasis on the importance of understanding the individuals within a group as well as the dynamics of their 'combined behaviour'. In order to effectively achieve this, a fine balance between analysis and empathy is required. Occupational Therapy interventions such a leisure, psychoeducation, social and practical activities are mostly achieved through task engagement (Garcia, Kennett, Quraishi & Durcan, 2005). Finlay (2004) identified four main types of groups used by occupational therapists, these included: activity-based groups (task and social) and support based groups (communication and psychotherapy). Task groups are mostly used to develop skills and are end-product focussed. Social groups provide an avenue for exploration, relaxation and fun and are focussed on facilitating social interaction and enjoyment. Communication groups focus on the sharing of group member's lived experiences and psychotherapy aims to increase an individual's insight into their current situation or difficulty.

Cole and Greene (2008) in a recent study compared two kinds of small therapeutic groups namely; unstructured psychotherapy groups and structured task-focussed occupational therapy groups and aimed to determine which type of group was most

favoured by a.) Patients with active psychosis and b.) Patients with borderline personality disorder. The study found that both patients with psychosis and borderline personality disorder preferred the structured occupational therapy sessions eventhough, the researchers had hypothesised differently.

Lim, Morris and Craik (2007) identified that the therapeutic use of activity, one of the central elements of Occupational Therapy, was seen as one of the most useful and important aspects of group therapy interventions. The study by Lim et al (2007) further identified that more than half of the participants reported that occupational group therapy sessions had helped them to function better in their day-to-day life, to meet their own needs and that they were more confident about their own abilities.

2.4 Theoretical Frameworks

Research conclusively suggests that group therapy is effective however despite this many patients are reluctant to engage with it. In order to understand this resistance, it is useful to explore wider theoretical models that try to explain people's health behaviours. Several explanatory models of health behaviour have been proposed to assist health care providers in attempting to understand and make sense of the intentions and motivations that underlie patient's behaviour. To this end, The Health Belief Model (Bekker, 1974), The Theory of Reasoned Action and Planned Behaviour (Ajzen & Fishbein, 1980) and The Social Cognitive Model (Bandura, 1986) are arguably well-known theoretical constructs for explaining patient's decision-making processes that guide their health behaviour and accordingly warrant further explanation, as detailed below.

2.4.1 The Health Belief Model (Bekker, 1974)

Bekker's Health Belief Model (1974) relies on the following key components in explaining patients' health behaviour, namely: perceived susceptibility, perceived severity/seriousness, effectiveness and perceived benefits versus perceived barriers. According to Bekker, perceived susceptibility refers to the probability that an individual assigns to personal vulnerability and how they interpret their current condition, this also links closely with self-efficacy. Perceived severity/seriousness refers to how serious the individual believes their condition to be and whether a specific behaviour (e.g. non-attendance to the group therapy programme) will have a negative effect on their wellbeing. Modifying factors are interrelated with these and include demographic, structural and social variables, while mediating variables, such as educational level, are believed to directly affect behaviour by influencing an individual's perceptions of susceptibility, severity, benefits and barriers. Bekker (1974) describes perceived effectiveness as the individuals' interpretation of the benefits that engaging in a specific behaviour (e.g. attending group therapy) will bring and perceived benefits versus barriers is how the person analyses the pros and cons of their decision. Within this category, perceived cost refers to barriers or losses or threats that interfere with the patients' decision-making processes, such as financial, psychological or emotional costs. According to Bekker, belief alone is not enough to motivate an individual to act. Taking action (cues to action) involves cognitively weighing the personal costs against the benefits expected as a result of engaging in a specific behaviour (such as attending group therapy). In the context of this model, therefore, patients that are unconvinced that a causal relationship exists between attending group therapy and their wellbeing, will not be motivated to attend group sessions.

Diagram 2.4.1 Health Belief Model (Bekker, 1974)
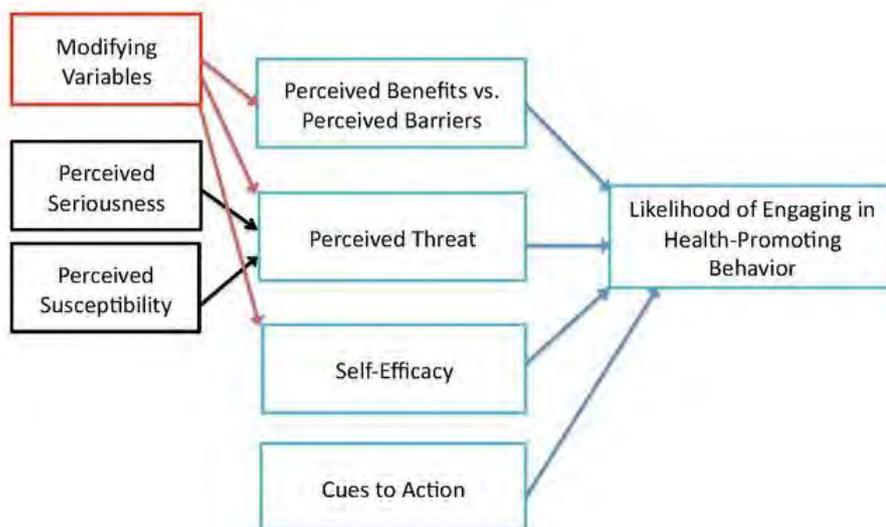
The model outlines that when perceptions of susceptibility and severity are high, a very minor stimulus may be all that is needed to initiate or cue action. However more intense stimuli may be needed to initiate action if perceived susceptibility and severity are low. These motivating factors will be important considerations in this study in attempting to understand cues to action that may be used to encourage patients' attendance and participation in group therapy. More recent formulations of The Health Belief Model have included self-efficacy as a key factor in patients' health behaviours (Stretcher, Champion & Rosenstock, 1997). Self-efficacy is influenced by mediating variables which in turn influence expectations.

2.4.2 The Theory of Reasoned Action and Planned Behaviour (Ajzen & Fishbein, 1980)

Ajzen & Fishbein's Theory of Reasoned Action and Planned Behaviour (1980) is a social-psychological approach to understanding and predicting the determinants of

human behaviour. The theory states that the intention to perform a particular behaviour is strongly related to the actual performance of that behaviour. By way of example, the intention to attend and participate in group therapy is strongly linked with actual attendance and participation. Intention is reported to be influenced by three major variables: subjective norms, attitudes and motivation. Subjective norms involve an individual's perceptions of what significant others believe about his or her ability to perform the behaviour coupled with their internal motivation (e.g. patient's perceptions about their significant others' opinions regarding their ability to successfully attend and participate in the group therapy programme).

Attitudes can be conceptualised in terms of values about a specific treatment modality (e.g. patients will develop certain values and ideas about group therapy as a treatment modality), while self-efficacy defined within this theme is the confidence an individual feels that she or he can successfully perform the desired behaviour. In the context of this study, this would mean that patient's perceptions of their own abilities and whether they believe that they would be a valuable and contributing member within the group could influence their attendance at these sessions.
The Theory of Reasoned Action and Planned Behaviour Ajzen & Fishbein, 1980) was designed to predict behaviour from intention and proposes a strong relationship between beliefs, attitudes, intentions and behaviour.

Diagram 2.4.2 Model of Reasoned Action & Planned Behaviour

(Ajzen & Fishbein, 1980)
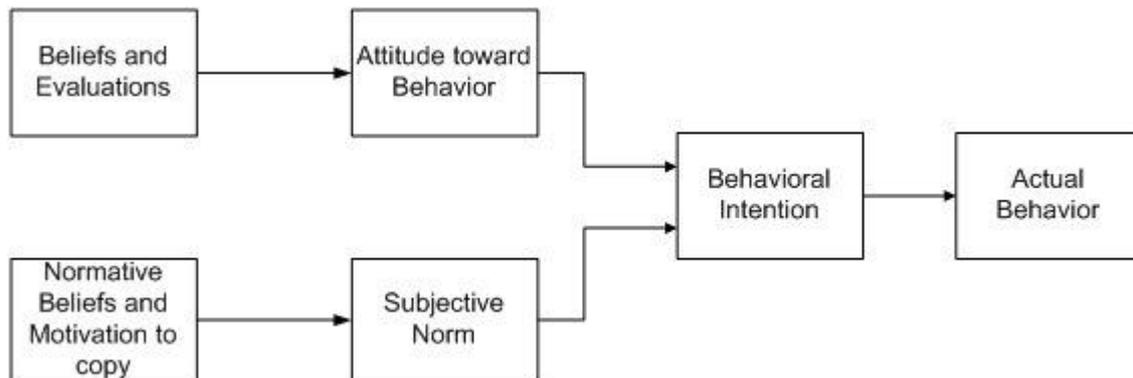
2.4.3 Social Cognitive Theory (Bandura, 1986)

Bandura's Social Cognitive Theory (1986) goes beyond individual factors in health behaviour change to include environmental and social factors. Reciprocal determinism forms the basic foundation of this theory and states that there is a continuous, dynamic interaction between the individual, the environment and behaviour. Thus a change in one of these factors will have an influence on the others. Key concepts associated with an individual include personal characteristics, emotional arousal or coping, behavioural capacity, self-efficacy, expectation, self-regulation, observational/experiential learning and reinforcement. Personal characteristics include demographics (gender, race/ethnicity, education, age etc.), personality, cognitive factors (thoughts, attitudes, beliefs, knowledge), motivation and skills. Emotional arousal or coping can interfere with learning and thus has a great influence on behaviour. This refers to an individual's ability to respond to emotional stimuli with various techniques, strategies and activities that can help the individual to deal with arousing situations, for example fear or anxiety. This is deemed to be

particularly applicable during the group process as many of the themes discussed are emotionally arousing and the patient would need to draw on their own coping mechanisms in order to regulate their emotion. Behavioural factors refer to the individual's possession of both the knowledge and skills necessary to perform a behaviour for example whether they possess the level of functioning to be able to actively take part in the group therapy process. Self-efficacy refers to an individual's confidence in their ability to perform a behaviour in various situations. Self-efficacy can be seen as an important mediating variable between knowledge, attitudes, skills and behaviour. Expectations are beliefs associated with the outcome of a behaviour and the value an individual attributes to the anticipated outcome of performing a behaviour i.e. the effectiveness of group therapy.

Diagram 2.4.3 Model of Social Cognitive Theory (Bandura, 1986)
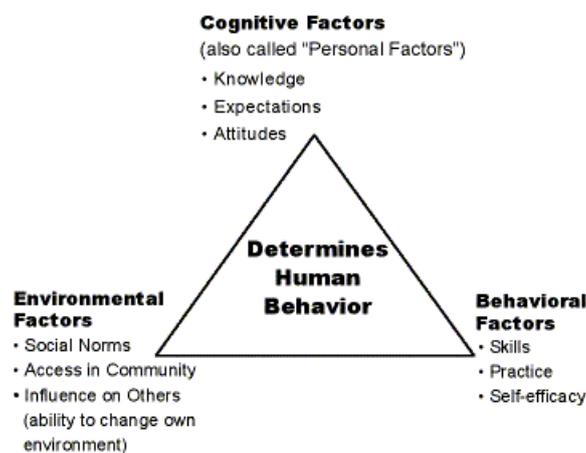
Self-regulation refers to the individual's ability to manage and control behaviour particularly during emotionally strenuous activities or discussions. Individuals make use of goal setting, self-monitoring and self-reinforcement to regulate performance during uncomfortable situations. Observational/experiential learning refers to the acquisition of a behaviour or skill through observation, this could be the observation of other group members coping strategies and self-soothing techniques during the

group session. Learning can occur through observation of another person's behaviour (modelling) or through personal behaviour (trial and error). These are two of the behavioural cornerstones on which group therapy is based (Yalom, 1995). Reinforcement refers to the consequences that affect the probability that a behaviour will be tried again; most individuals are most easily motivated by rewards and incentives.

These three models of health behaviour provide a number of possible variables that can be explored further in this study in order to gain a better understanding of the factors affecting attendance and participation in group therapy. Armed with this new found understanding, the researcher intends to develop a workable programme for action to counteract limited attendance and participation in the group therapy programme offered at the study site. Should this intervention prove successful over time, it may be replicated in similar settings in order to create a more comprehensive treatment experience for the psychiatric inpatient.

2.5 Summary

The chapter above has detailed existing research into the theme of group therapy attendance and participation and various researchers' attempts to try to predict this. Within the South African context very little research was available which again indicates why the need for a study such as this is required. The researcher has chosen to focus on one of the most popular group therapy researchers and applied Yalom's (2005) theories and therapeutic factors as to why group therapy works. The theoretical frameworks chosen have been deemed the most applicable to the current study as a way of trying to understand and analyse patient's opinions and behaviours.

Chapter 3: Method & Research Design

3.1 Introduction

In the previous section it was highlighted that very little research into group therapy attendance and participation exists and even less within the South African context. In this regard it made it impossible to replicate or further develop any existing research and thus the methodological approaches had to be novel and unique. Based on this, the researcher made the decision to focus on a qualitative design using semi-structured interviews to help understand patients lived experiences of group therapy, as the data collection methods. These methodologies were deemed the most successful at collecting the 'rich' data required for the analysis for this particular study.

3.2 Research Questions

According to the theoretical frameworks used, namely: The Health Belief Model (Bekker, 1974), The Theory of Reasoned Action and Planned Behaviour (Ajzen & Fishbein, 1980) and The Social Cognitive Model (Bandura, 1986), the researcher used these models together with the study objectives to formulate the specific research questions outlined below:

- What are patients' attitudes, opinions and perceptions of group therapy as an effective or non-effective treatment modality? *(Based on The Health Belief Model, Bekker (1974))*

- What are patients' perspectives of the positive and/or negatives consequences or outcomes that have resulted from attending/not attending the group therapy programme? *(Based on perceived cost and effectiveness of The Health Belief Model, Bekker (1974))*

- What are the factors that motivate and hinder patients in their attendance and participation within group therapy setting? *(Based on the cues to action of The Health Belief Model, Bekker (1974))*

- Do methods exist to enhance group therapy attendance and participation within the inpatient psychiatric setting? *(Based on Social Cognitive Theory, Bandura (1986))*

- What are patients' perceptions of the social support that they receive from significant others (doctors, psychologists, family, friends etc.) regarding the attendance of group therapy? Does this have an impact on their attendance or participation? *(Based on the Theory of Reasoned Action and Planned Behaviour, Ajzen & Fishbein (1980))*

- Do any relationships exist between demographic characteristics, such as age, gender, race or psychiatric diagnosis, and group therapy attendance? *(Based on self-efficacy principle of The Health Belief Model, Bekker (1974))*

3.3 Theory informing the Methods used

For the purpose of this study the researcher has made use of a qualitative research design using conventional methodology. Qualitative research design adopts a method of inquiry that aims to gather in-depth understanding of human behaviour as

well as to define the reasons or decisions that govern these behaviours (Savin-Baden & Major, 2013). Denzin, Norman and Lincoln (2005) in their published Handbook of Qualitative Research indicated that qualitative methods explore the why and how of a person's decision making and not just the what, where and when.

When looking at the application of conventional methodology within a qualitative research design, information or data produced is only applicable to the particular cases studied and does not try to make more general conclusions or informed assumptions to the greater 'unstudied' populations.

A phenomenological approach with its roots in humanistic psychology was adopted as the best approach to understand and describe the participants' lived experiences of group therapy. According to Groenewald (2004) in his article, 'A Phenomenological Research Design Illustrated' he ascribes the operative word in phenomenological research as 'describe.' Whereby the aim of the researcher is to describe, as accurately as possible, the phenomenon or experience remaining true to the facts given.

In 1999, Welman and Kruger (1999) defined the focus for researchers using a phenomenological approach, '…the phenomenologists are concerned with understanding social and psychological phenomena from the perspectives of people involved' (p. 189). They go on to say that the participants are the experts on their own experiences and should be treated as such. True to this, the researcher will ensure that during this process that the group therapy attendee or non-attendee is respected as the 'expert' in the field of group experiences. Further to this the inclusion and use of inductive reasoning assumes that theory should be constituted from the data rather than starting from a pre-existing theory (Heit & Rotello, 2010).

Although in saying this, no research is wholly inductive as researchers are theoretically sensitised before they approach data analysis. This theoretical sensitivity introduces a deductive element to analysis, as prior conceptions and understandings are tested against the data. Instead of viewing this as a limitation, Strauss and Corbin (1994) maintain that this can be used advantageously: "Researchers carry into their research the sensitising possibilities of their training, reading and research experience, as well as explicit theories that might be useful if played against systematically gathered data, in conjunction with theories emerging from analysis of these data" (p.277).

Although there are various techniques to be used in qualitative research (semi-structured interviews, focus groups, life stories etc.) their common goal is to find out the point of view of the research subjects. In order to discover their point of view, understanding, meaning making and interpretation, interviews were carried out in a flexible and semi-structured manner over the research period of 6 months. Questions were open ended and interviews conducted as informal conversations.

3.4 Study Site and Location

The study site was selected using a convenience sampling method, as the researcher was employed at the Psychiatric Clinic during the early parts of the study. The clinic is a private (non-government) inpatient psychiatric clinic where a patient is referred by a Psychiatrist or Psychologist for in-hospital care due to the severe impact that their current psychiatric condition has had on their day-to-day functionality. The clinic currently admits a large variety of psychiatric illnesses, the most common being: Major Depressive Disorder, Bipolar Mood Disorder, Anxiety Disorders, Schizophrenia and Personality Disorders. The patient is cared for by

nursing staff and their referring psychiatrist and are encouraged to take part in the group therapy programme during the day. The group therapy programme is run by a variety of health care providers including: Occupational Therapists, Psychologists, Social Workers, Occupational Therapy Assistants and Nurses who offer a multi-disciplinary and diverse therapeutic programme. The programme runs on a three-week cycle with each week focusing on a single broad theme. The three themes that get covered in the cycle are Self Awareness, Emotions and Relationships. A large variety of groups are offered including: lectures/discussions, psycho-education, non-directive/process groups, activities, practical life skills groups, games and support-based groups. In conjunction to group therapy, the patient is referred to a Psychologist who sees them for individual psychotherapy sessions during their admission.

Due to the convenience of the study site selection, it ensured that the target population was readily available and easily accessible for the research study. The population admitted to the clinic were most often from middle to upper class socio-economic environments, mostly employed and living within the Pietermaritzburg area and surrounding districts.

3.5 Study Population

The population (N) for the study comprises psychiatric patients admitted to a private psychiatric inpatient hospital in Pietermaritzburg, South Africa during the research and data collection time period November 2013 – April 2014. In this study, the sample group comprised of patients with diagnoses of Major Depressive Disorder and Bipolar Mood Disorder due to the frequency of patients admitted with these specific diagnoses

3.6 Study Sample and Size

Guest, Bunce and Johnson (2006) in their article 'How many Interviews is enough?' came to the realisation that there is very limited research as to how many interviews is an adequate amount in order to reach data saturation in qualitative research. Morse (1995) summed up the current situation when she noted that, 'Saturation is the key to excellent qualitative research,' but then went on to say, 'there are no clear published guidelines or tests of adequacy for estimating the sample size required to reach saturation' (p. 147). More recently however, researchers Kerr, Nixon and Wild (2010) did an analysis on a homogenous patient population and found that data saturation is regularly achieved within 10 individual interviews with some evidence indicating that this can be achieved with fewer. The researcher estimates that this in this study, the number of interviews would more than likely not exceed 6-10 interviews for each sample group.

Following the target population's participation in therapy over the specified time period, two sample groups were purposively selected, based on their rate of attendance during their admission as an inpatient, i.e. those that showed good attendance to the group therapy programme (referred to as attendees) versus those that did not (referred to an non-attendants). The reason it was chosen to split the sample population into these two defining groups was to enrich the qualitative data by being able to compare and contrast the responses of those patients that attended the group therapy programme versus those that did not, in terms of opinions, perspectives, and demographics. The following criteria were used to differentiate the two groups:

Group 1: (n=10) <u>ATTENDEES</u> i.e. Patients that attended an average of 60% or more of the group sessions available to them during their admission to The Clinic.

Group 2: (n=6) <u>NON-ATTENDEES</u> i.e. Patients that attended an average of 20% or less of the group sessions available to them during their admission to The Clinic.

3.7 Inclusion and Exclusion Criteria

According to Morse (1991), a 'good informant' should possess the following characteristics: knowledgeable about the topic- an expert by virtue of involvement in the specific field (e.g. attendance to the group therapy programme); able to reflect and provide detailed experiential information about the area of investigation; willing to talk. This was always borne in mind when meeting a potential participant.

Inclusion and exclusion criteria that were considered in sampling procedure are detailed in below:

Table 3.7.1: Inclusion and Exclusion Criteria for Sample Selection

Inclusion Criteria	Exclusion Criteria	Reason/Explanation
Inpatient	Outpatient	The patients need to be admitted (inpatient) to the clinic as the site for the research study is an inpatient facility and does not allow for outpatient treatment.
Physically Healthy Individuals	Severe General Medical Condition	If a patient is physically ill, it may interfere with their ability to attend the group

		therapy programme
Age: between 18 & 65 years old	Age: below 18 years or older than 65 years	Patients below 18 years are admitted to the Adolescent Unit where group participation is compulsory. Patients above 65 years old are more likely to have physical and cognitive difficulties which may interfere with their group therapy attendance or participation
Cognitive function intact	Intellectual Impairment or acute psychotic symptoms	Patients are required to possess adequate logical cognitive function as any mental deficit/impairment/severe psychosis will render the patient unable to follow the flow of discussion during the group therapy programme. They would also not be able to make an informed decision as to whether or not to participate in the research study denying them their autonomy.
Medical Aid patients	Private fee paying patients	If a patient is responsible for paying for their admission privately, it is more likely that they will not attend all groups as they would be concerned with the potential cost implications.

English language proficiency	No English language proficiency	Due to the fact that the researcher is only proficient in the English language, participants need to be able to express themselves in this language. This does not mean that the participant has to have the English language as their first language and this is identified as a limitation in this study.

Patients' group attendance was monitored by the programme co-ordinator at the clinic and any patient that fell into either the attendee or non-attendee sample group category and met the inclusion criteria for the study, was then individually approached to take part in the research, should they so desire.

3.8 Data Collection Instrument

The data was collected by use of semi-structured individual interviews until such time as data saturation was achieved. In recent times, data saturation has become the gold standard by which sample sizes are determined in qualitative research (Guest, Bunce & Johnson, 2006) and is defined as the point where data collection and analysis reveal little or no new valuable information. Data saturation was achieved at different points for the two groups which explains the differing number of interviews conducted between the groups (Attendees n=10, Non-attendees n=6).

According to DiCicco-Bloom and Crabtree (2006), semi-structured, in-depth interviews are frequently used by health professionals and these interviews should

be open, direct, verbal questions which are used to elicit detailed narratives and stories. Semi-structured interviews were selected as the primary data collection tool as they allow for more individualised and personal opinions than focus groups. Further, it was deemed to be very difficult to enlist participation of non-attendees to group therapy in a focus group discussion.

A literature evaluation, detailed below, revealed extensive praise for semi-structured interviews as opposed to questionnaires or telephonic interviews. Semi structured interviews have the potential to overcome the poor response rates of a questionnaire survey (Austin, 1981) and in most cases face-to-face contact with the researcher will motivate respondents to participate who would otherwise not have bothered with a questionnaire (Gordon, 1975). The design of the interviews is well suited to the exploration of attitudes, values, beliefs and motives (Richardson, Dohrenwood & Klem, 1965) and provides the opportunity for the researcher to evaluate the validity of the respondent's answers by observing any non-verbal cues, particularly during difficult or sensitive issues (Gordon, 1975).

The researcher herself aimed to follow an interview process detailed in sections to follow. Due to feasibility and difficulty in attaining finance for the study, the researcher had no choice but to perform the interviews herself. During the interview process, the participant was escorted to a quiet therapy room with no distraction or disturbances. During the discussion, the researcher aimed to cover the following themes during a predicted 15-25 minute semi-structured interview:

- Patient perceptions of group therapy prior to admission
- Patient perceptions of group therapy after exposure
- Patient's deemed effectiveness of group therapy as a treatment modality

- Personal experiences as a group member (positive and/or negative)

- The positive and/or negative outcomes of their group therapy experience

- The motivating factors that encourage group therapy attendance and the hindering factors that deter the patient from group therapy attendance

- Patient perspective of the social support/lack thereof from significant others (family, partner, friends, health professionals etc.) regarding group therapy attendance

- The patient's opinion as to what could be done in order to improve group therapy attendance and participation e.g. rewards, incentives etc.

Through these individual interviews valuable and rich data was collected that authentically demonstrated the knowledge, attitude, behaviours and opinions of the inpatients regarding group therapy.

3.9 Data Collection

Prior to the initiation of the data gathering process, the researcher conducted a pilot study involving a semi-structured interview, in order to test the data gathering instrument and interview schedule. This also aided the researcher in determining any shortfalls of the instrument or data gathering methods. The interview was audio recorded and transcribed to form the data source. In 2005, Nwanga spoke of pilot studies as being useful in many ways by improving the internal validity of a questionnaire or scale. Pilot studies can also be used to assess the feasibility of the main study by establishing whether the sampling frame and the technique are effective through giving feedback on the logistics of the data collection method (Nwanga, 2005).

The researcher followed the guidelines highlighted by Peat, Mellis, Williams and Xuan in 2002 about how to successfully implement a pilot study and based most decisions on their guiding principles. A pilot interview was administered in exactly the same way as it would be in the main study e.g. location for interview, interview schedule, exclusion and inclusion criteria etc. After the instrument was used in the pilot, the researcher asked the participant if anything was ambiguous or required clarification and adjusted the questions or interview schedule accordingly. The participants identified that some of the terms and language that the researcher used were too complicated and difficult to understand and one question was quite open to misinterpretation and ambiguous. Further to this no major areas for correction were identified and there was no need to pilot again. Finally, once all the finer adjustments were made to the interview schedule, the researcher consulted with her supervisor for any further advice or assistance before initiating data collection.

During the data collection period, the programme co-ordinator at the study site, who monitors the group attendance, contacted the researcher when a patient fell into the category of attendees or non-attendees research participant (see Sampling Procedure). That individual was then personally requested to discuss their participation in the study, should they so desire. Once all aims and objectives were explained and the participant had provided signed informed consent (see Appendix I), an appointment date for conducting the interview was set. Rose (1994) advises that before initiating an interview, that the researcher complete a brief checklist highlighting practicalities and areas that need to be clarified. The checklist entailed explanations of the following: the purpose of the interview; clarification of the topic of discussion; format of the interview; approximate length of the interview; assurance of confidentiality; purpose of the audio recorder, permission to use the data for

research purposes; assurance that the participant may seek clarification of questions; assurance that the participant may decline to answer a question or terminate participation at any time (Rose, 1994).

By way of preparation for the interviews, the researcher identified the therapy consulting rooms as a quiet, private and comfortable environment to meet the research participants (Burns & Grove, 2005). Disruptions would be minimal and the office had a comfortable couch for the participant to sit on. Once the participant was settled, the audio recording of the interview was initiated. The researcher established basic rapport by way of general conversation and interactions. The researcher then moved to open ended, superficial questions and gently progressed to deeper aspects as the participant started to feel more comfortable. DiCicco-Bloom and Crabtree (2006) emphasise the importance of establishing rapport as being beneficial to the quality of data collected. Furthermore they mention the importance of the first question, stating that while it must be clearly focussed on the research, it should be open-ended and broad to place the participant at ease. As the interview progressed and both parties started to feel more comfortable, questions continued to remain open-ended so that the participants were encouraged to reflect on and identify their true feelings about the subject matter at hand (Warren & Kerner, 2005). The majority of the participants started to guide and teach the researcher about their lived experiences, this is the essence and goal of the interview (DiCicco-Bloom & Crabtree, 2006). Towards the end of the interview, it was important that both parties felt ready to terminate the discussion; the researcher asked if the participant had anything else to add. Following this, the researcher then thanked the participant for their time and energy, ensuring to mention how valuable their opinions had been.

After the interview, the researcher made some reflexive notes about her personal experiences of the participant, body language or any other points of information to remember during transcription. Following this, the researcher began with the verbatim transcriptions of all of the audio recordings of the interviews. According to DiCicco-Bloom and Crabtree (2006) this process is often a lot more difficult than expected and that capturing the wording accurately involves playing the recorder several times over which often takes a large amount of time.

3.10 Data Management and Storage

All data collected from this study is currently stored electronically in a password restricted data base. All identifying data as well as confidential papers are stored within the researcher's personal safe. All data (electronic or otherwise) will be kept for a period of 5 years where after it will be deleted or shredded.

3.11 Data Analysis

Thematic analysis was chosen as the most applicable type of data analysis to use and resulted in a useful representation of the sample groups' attitudes and opinions. The section to follow details the process of thematic analysis.

Thematic analysis can be described as a qualitative analytic method for identifying, analysing and reporting patterns (themes) within the data collected (Braun & Clarke, 2006). It also organises and describes the data in rich detail and interprets the various aspects of the research topic (Braun & Clarke, 2006). Thematic analysis encompasses a broad flexibility in that multiple theories and a variety of epistemologies can be used (Boyatzis, 1998). This allows the data to span a wide range of analytic options and although it is mostly an advantage, it can be a

disadvantage too in that the development of specific guidelines can be difficult. In his paper, 'Transforming qualitative research,' Boyatzis (1998) highlighted that thematic analysis is a relatively simple method of data analysis to learn and is highly recommended for the younger or inexperienced researcher. Based on the steps identified by Braun and Clarke (2006) in their paper 'Using Thematic Analysis in Psychology', the researcher decided to mirror these in her approach to thematic analysis of the data collected. The steps that were followed are highlighted below:

1. Prepare the data for analysis

This process involved the verbatim transcription of all of the semi-structured interviews that were recorded during the data collection process. The researcher personally transcribed the interviews in order to ensure data familiarisation and to optimise accuracy.

2. Initial reading of the text

During this step, the researcher numbered each line to assist with cross referencing and then read through the data while taking note of the major issues and themes that were embedded in the data.

3. Re-read the texts and annotate thoughts in the margin

The researcher re-read the text and wrote some thoughts or potential ideas into the margin. This process promoted open coding which identified new information by de-contextualising parts of the data.

4. Sort items of interest into basic themes

According to Braun and Clarke (2006) a theme captures something important about the data in relation to the research idea and provides meaning within the data collected. In order to aid this process, the researcher used the research questions as a framework to structure the data analysis. Themes were identified that were related to the specific research questions. Although it introduced an element of deductive reasoning, it supported a clear and logical analysis as the data was methodically and accurately encapsulated into the correlating objective. The themes were kept as simple as possible in order to facilitate ease, flexibility and understanding.

5. Examine the basic themes and attempt initial definitions

The researcher began trawling through the data that was defined into the various objective categories. Once it was clear that the themes were correctly arranged into the objective headings, a meaning and a name were given to each theme as well a flexible, provisional definition. This was done by investigating which themes reoccurred more often and attempting to categorise them according to the main subject within the objective that was being discussed.

6. Construct the final form of each theme

During this step, the researcher re-examined the name, definition and supporting data for the final construction of each theme.

7. Report each theme

After further analysis the researcher then finalised each of the themes within the research questions and the data analysis process was completed when the results were compiled into the research finding report in the section to follow. The frequency of the occurrence of each theme in the transcripts was counted and then the themes

were rank ordered according to frequency in order to establish which themes were the most commonly expressed by participants. This method of quantifying qualitative data was informed by the methods used traditionally in content analysis (Vaismoradi, Turumen & Bondas, 2013).

The study did gather some quantitative data on group attendance and demographic variables of participants (age, race, gender, diagnosis on admission) which allowed a quantitative analysis of any possible significant relationships between group attendance and demographic variables. This analysis was briefly included as an add-on to the main study to see if any interesting relationships emerged. The Fischer's Exact test (Fischer, 1925) was used because it is able to be used with small sample sizes.

3.12 Trustworthiness and Rigour

According to Lincoln and Guba (1985), qualitative researchers should adopt different terminology in a bid to distance themselves from the positivist paradigm often seen in quantitative research. However much of Silverman's (1993) work has highlighted the more traditional terms that are used to quantitative research and also showed that the same terms can be used for quantitative and qualitative research as long as certain issues are dealt with (Silverman, 1993).

The table below indicates the discrepancy in terms used by the different researchers:

Table 3.12.1 Comparison of terms for ensuring Trustworthiness and Rigour

Guba and Lincoln's (1985) recommended terms for ensuring trustworthiness and rigour	Traditional terms for ensuring trustworthiness and rigour
credibility	internal validity
transferability	external validity/generalisability
dependability	reliability
confirmability	objectivity

Due to the nature of their recommendations, the researcher has chosen to adopt Guba and Lincoln's qualitative terms as a way of ensuring trustworthiness and rigour in the current study. In his paper 'Strategies for ensuring trustworthiness in qualitative research projects' Shenton (2004) suggests many strategies to optimise credibility, transferability, dependability and confirmability; these are discussed and applied to this study in the paragraphs below.

Credibility can be described as confidence in the 'truth' of the findings of the study and the belief that a true picture of the phenomena under investigation has been presented. Credibility is argued as the most important criteria in ensuring trustworthiness (Guba & Lincoln, 1985). The question that needs to be asked is 'How congruent are the findings with reality?' As a way of ensuring credibility the

researcher made use of well-established research models that have successfully been utilised in comparable research studies. This included the use of semi-structured interviews as well as thematic analysis. The researcher was very familiar with the participants and the organisation (the clinic) as she was employed there, this allowed for prolonged engagement and observations to establish trust between all of the parties involved. The researcher deployed tactics to ensure honesty as far as possible when contributing to the data. Every participant who was approached was given opportunities to refuse participation thereby ensuring that those who took part were genuinely willing and open to offering data freely. Reassuring the participants that there are no right answers to the questions allowed them to feel more comfortable to speak openly and spontaneously. Furthermore, due to the fact that the researcher was employed at the site for a part of the study, the participants had to be reassured that they would not lose credibility in the eyes of the managers of the organisation and that the researcher was there in a completely independent capacity. Due to this however, the potential for researcher bias needed serious consideration. Financial and time restraints limited the researcher's option of employing an outside data collector which would have been first prize in limiting any potential bias. Smyth and Holian (1999) suggest that researchers who conduct research in their own organisation can offer a unique perspective because of their knowledge of the culture, history, organisation, logistics and people involved. They do however; acknowledge the potential problem of researcher credibility, both within the organisation and at the point of reporting the research findings. As an 'insider-researcher' (Smyth & Holian, 1999), the researcher had to be committed to the transparency of the research process, the philosophy of openness and collaboration and the focus on giving a 'voice' to the participants

Iterative questioning was used to double check the honesty of the participants' responses. This involves re-phrasing the questions to identify if there is consistency between the participant's two replies. Consistency indicates that the responses were both honest and valid and inconsistency indicates that the participant may not have been giving completely honest replies and this should be clarified with further questioning or the data completely discarded. During the process of write up and analysis of the data, the researcher would often approach colleagues for advice or request that they review a certain section. The researcher's project was also presented to Occupational Therapy peers and was discussed with them. This allowed the researcher to refine any inconsistencies and for her pre-existing assumptions or inaccuracies to be challenged and addressed. Many arguments were strengthened as peers asked for clarification. As previously mentioned, the researcher made use of reflexive notes after the termination of an interview, this aids in identifying the researchers own progressive or developing constructs. Koch and Harrington (1998) suggest that reflexivity limits researcher bias and enables self-examination which means that the researcher's own values, assumptions and prejudice must be acknowledged. Koch and Harrington (1998) also draw attention to interviewer bias, where the interviewer, who is also the researcher in this instance, may subconsciously give subtle clues with body language or tone of voice, that may influence the participant into giving answers directing towards the interviewer's own opinions, prejudices and values. The researcher at all times tried to keep her own opinions aside and to follow a methodical and logical direction throughout the interview.

Transferability includes the steps taken in ensuring that sufficient detail of all parts of the study is given in order to allow the findings to be applied to other similar settings.

As far as was possible, the researcher highlighted and explained all details of the study as clearly as possible as well as any assumptions that were central to the study itself. Due to the nature of the study site and the fact that the organisation has applied the same therapeutic model to various clinics in South Africa, the transferability of this research is deemed to be good and was aided by a thick description of all steps taken. The work of Cole and Gardner (1979) emphasised the important of the conveying to the reader the boundaries and limits of the study. This is improved by providing information of the following: a) the number of organisations taking part in the study (see Study Site); b) any restrictions in the type of people who contributed data (see Inclusion and Exclusion criteria); c) the number of participants involved in the fieldwork (see Sample); d) the data collection methods that were employed (see Data Collection); e) the number and length of the data collection sessions (see Data Collection Instrument); f) the time period over which the data was collected (see Study Population).

With many similarities to reliability, *dependability* is the idea that is the research were repeated, in the same context, with the same methods and with the same participants, that similar results would be obtained. Obviously within this study, the group therapy sessions or the therapists providing the services may change which introduces many variables into the dependability of some qualitative research studies. Lincoln and Guba (1985) argue that in practice transferability and dependability are very closely related and that ensuring transferability often aids the dependability of a study. Within the study, the researcher explained all of the details as thoroughly as possible and made use of an interview schedule (see Appendix II) ensuring that future researchers would be able to replicate the study if so desired.

Confirmability is the notion that findings of the study emerge from the data and are shaped by the participants and not from any researcher bias. Due to the fact that the researcher was employed at the study site for a period of time, the potential for researcher bias needed serious consideration. Financial and time restraints limited the researcher's option of employing an outside data collector which would have been first prize in limiting any potential bias. Smyth and Holian (1999) suggest that researchers who conduct research in their own organisation can offer a unique perspective because of their knowledge of the culture, history, organisation, logistics and people involved. They do however; acknowledge the potential problem of researcher credibility, both within the organisation and at the point of reporting the research findings. As an 'insider-researcher' (Smyth & Holian, 1999), the researcher had to be committed to the transparency of the research process, the philosophy of openness and collaboration and the focus on giving a 'voice' to the participants. At all times when reaching a cross road in decision making, the researcher explained the reasons for various choices and made clear why one choice was taken over another option.

3.13 Ethical Considerations & Confidentiality

Prior to any research being conducted, written permission was granted from both the University of KwaZulu-Natal Biomedical Research Ethics Committee, as well as the site for research, the Psychiatric Clinic (See Appendix III and IV).

Throughout the study the protection of the patient's human rights, respect, beneficence and justice was of optimal priority. Since working with inpatients with psychiatric illnesses is often met with ethical dilemmas, this study was only

performed on voluntarily admitted patients, as the Clinic is a voluntary institution. Therefore their right to self-determination was not impinged upon.

To comply with informed consent, the researcher clearly explained all the aims and objectives of the study, before the patient granted their permission. The patient was asked to sign a consent form. In keeping with autonomy, this consent form detailed their voluntary participation and that they are entitled to withdraw from the study at any time with no explanation and no consequences or harm whatsoever. The researcher had to receive additional informed consent as the interview would need to be audio-recorded for transcription purposes and permission was required for this. In line with the recommendations from the BREC (Biomedical Research and Ethics Committee) an extra signature from the participant authorising audio recording was required and received.

Due to the sampling procedures identified, each participant had the intellectual capacity to be able to understand the outcomes of their behaviour thus ensuring honesty and their right to dignity and autonomy. The anonymity of data was upheld and each participant was given a specific code, known only to the researcher, in place of their name. All data was safeguarded in an access controlled data base and will be destroyed after 5 years. This fosters patient confidentiality and clearly disclosing the plans for the research allows the participant to see that the researcher is open, honest and ethical in her practices.

In order to ensure non-maleficence, the researcher made time available for the participant to debrief with the researcher herself or with an independent therapist should the participant become overwhelmed or upset.

The study did not interfere with patient care or therapy while the patient was admitted at the study site and the subjects do have the opportunity to receive the results of the study, at a later stage, if they so desire. The researcher also has the ethical responsibility to share any novel findings with other professionals in the field of group therapy and mental health, which will be done by means of a publication of the findings of the study in a professional article or journal.

Adhering with ethical requirements and upholding autonomy, the participants were also given the opportunity to withdraw from the study at any given time without having to provide the researcher with a reason for this decision.

3.14 Summary

The chapter above encompasses the thought processes and decisions made in terms of methods used throughout the research study. All decisions have sound literature support and much time has been taken to ensure that the most applicable and accurate designs were chosen. The researcher has highlighted the importance of trustworthiness and rigour as a fundamental core to the applicability and credibility of the study. The details of the data instrument are discussed in this chapter however a copy of the interview schedule in available in Appendix II. The researcher has in-depth defined the processes of thematic analysis and has emphasised the importance of ethical considerations and sensitivities when engaging in research with patients with psychiatric conditions.

Chapter 4: Results and Findings

4.1 Introduction

The chapter to follow details the results and findings from the study as well as the inclusion of many patients verbatim first hand reports of their group therapy experiences. Results are analysed according to the themes identified through the process of Thematic Analysis while using the research questions as a guiding framework.

4.2 Demographic Details and Group Therapy Attendance

The sample group was based upon voluntary inpatients at a psychiatric clinic, in Pietermaritzburg. The demographics of the study are detailed below according to:

- Gender   (Sex of participant i.e. Male or Female)
- Race   (Ethnic group i.e. African, Indian or Caucasian)
- Age   (Years of age)
- Diagnosis   (Self-reported Psychiatric diagnosis)

4.2.1 Gender:

Table 4.1: Gender Demographics of the Sample Population

Sex	Total Sample (n)	Attendees (n)	Non-Attendees (n)
Male	25% (4)	20% (2)	17% (1)
Female	75% (12)	80% (8)	83% (5)

The total sample population is made up of 25% males and 75% females. This indicates that the majority of the opinions analysed would be those of women. The

attendee and non-attendee groups show a similar proportion of men to women being 1:4 and 1:5 respectively. There were no significant associations between gender and attendance (p< 0.999, Fisher's Exact Test).

4.2.2 Race:

Table 4.2: Race Demographics of the Sample Population

Race	Total Sample (n)	Attendees (n)	Non-Attendees (n)
African	50% (8)	50% (5)	66% (4)
Caucasian	25% (4)	30% (3)	17% (1)
Indian	25% (4)	20% (2)	17% (1)

The race demographics for the total sample indicate that the majority of respondents were African (50%) and the rest of the sample was made up of 25 % Caucasian and 25% Indian participants. The attendees group also shows a 50% African population however a higher percentage was noted for the Caucasian group (30%) and subsequently a smaller percentage for Indian participants (20%). However there were no significant associations between race and attendance (p< 0.999, Fisher's Exact Test).

4.2.3 Age:

Table 4.3: Age Demographics of the Sample Population

Age	Total Sample (n)	Attendees (n)	Non-Attendees (n)
20-30 years	25% (4)	20% (2)	33% (2)
31-40 years	44% (7)	40% (4)	50% (3)
41-50 years	19% (3)	20% (2)	17% (1)
51-60 years	12% (2)	20% (2)	-

The age demographics found that the majority (44%) of the total population were found to be between the ages of 31 and 40 years of age. This was followed by the age group 20-30 years with 25%, 41-50 years with 19% and 51-60 years with 12%. There were no significant associations between age and attendance (p=0.8, Fisher's Exact Test).

4.2.4 Diagnosis:

Table 4.4: Diagnosis Demographics in the Sample Population

Diagnosis	Total Sample (n)	Attendees (n)	Non-Attendees (n)
Major Depressive Disorder (MDD)	69% (11)	70% (7)	67% (4)
Bipolar Mood Disorder (BMD)	31% (5)	30% (3)	33% (2)

The self-reported diagnosis demographics for all groups showed a higher percentage for Major Depression (69%) as compared to Bipolar Mood Disorder (31%). There were no significant associations between diagnosis and attendance (p=0.587, Fisher's Exact Test).

4.3 Results

As previously mentioned and explained, the results will be presented using the research questions for the study as the structural framework.

4.3.1 Patients Attitudes, Opinions and Perceptions of Group Therapy

This research question explored the patients' experiences and opinions on the effectiveness of group therapy as a treatment modality. Their opinions were discussed regarding how they felt *prior* to attending the sessions and they were then

encouraged to relate their personal lived experiences (*after* attending sessions) and to judge whether they felt that group therapy was an effective treatment modality.

Table 4.3.1: Thematic Analysis of Patients' Attitudes, Opinions and Perceptions of Group Therapy

#	Theme	Attendees (n=10)	Non Attendees (n=6)	Total Sample (n=16)
1	Scared/Fear	70% (7)	50% (3)	63% (10)
2	Negative stereotypes portrayed by media or society	20% (2)	-	13% (2)
3	Previously experienced groups	-	17% (1)	6% (1)
4	Effective? Yes	100% (10)	100% (6)	100% (16)
	Effective? No	-	-	-

The thematic analysis identified that many of the total sample population (63%) felt scared and apprehensive to share the details of their life or current circumstances. Other fears that the participants spoke of were fear of the unknown, fear of being judged by others and fear of talking in a group of people. The majority of attendees (70%) experienced this fear and 50% of non-attendees identified similar fears when they were initially introduced to the group therapy programme One attendee mentioned, on her opinions when she was told about the group programme,

"I was uncomfortable with it (group therapy), cause I didn't want to be discussing my problems and thought that some people would judge me a lot. You know, saying that I can't experience these problems; I should just get on with life. But when you actually attend group therapy it's not that."

Upon admission to the psychiatric hospital many of the inpatient participants spoke of the fear of the unknown. This uncertainty made many people feel scared and unsure. Some of the participants preferred to keep their problems private and did not want to speak to others about it. A non-attendee noticed these feelings when initially told about group therapy.

"At first I didn't feel comfortable talking in the group because I don't usually talk about how I feel to other people and I don't show emotion. Yeah...I was like shocked."

Group therapy is a treatment modality that few people have experienced directly and so some of the participants (20% of attendees which worked out to 13% of the total sample) thinking was 'stigmatised' by what they had seen in the media and on television.

An attendee said,

"The only thing that I had seen was in the movies portraying it (group therapy) in a combat situation where guys had been suffering from PTSD and guys were very angry and a lot of swearing and whatever. I was also scared there would be strait

jackets that we had to wear. (Laughs).So I wasn't very impressed to be told I had to go to groups. I was very apprehensive."

Interestingly in the final theme we see that all of the participants of the attendee group and the non-attendee group (100%) agreed that group therapy was an effective modality for the treatment of Depression and/or Bipolar Mood Disorder. A participant mentioned this when asked about group therapy effectiveness:

"Yeah I would say it is very effective because when you are depressed you don't really feel like being around anyone or doing anything. Most of the activities that we do during group therapy includes a lot of talking, active participation, a lot of thinking about how you are going to approach specific problems, how to deal with those as well as positive things like advice."

4.3.2 Patients Perspectives of the Outcomes of Attending / Not Attending the Group Programme

The second research question aimed to explore the patient's perspective of the negative or positive consequences or outcomes experienced as a result of attending or not attending the group therapy programme. This question was strongly linked with the perceived effectiveness criteria of the Health Belief Model (Bekker, 1974).

The thematic analysis is summarised in table 4.3.2 below.

Table 4.3.2: Patients Perspectives of the Positive (+) or Negative (-) Outcomes of Attending/Not Attending the Group Programme

#	+ or −	Theme	Attendees (n=10)	Non Attendees (n=6)	Total Sample (n=16)
1	+	Helpful, supportive, encouraging and understanding space where you never felt judged	80% (8)	83% (5)	81% (13)
2	+	Helps you to see your problem/circumstances in perspective as you listen to others experiences	60% (6)	67% (4)	63% (10)
3	+	A safe forum to release and discuss pent up emotion	60% (6)	50% (3)	56% (9)
4	+	Educational, learn new ways of coping and get to know yourself better	70% (7)	33% (2)	56% (9)
5	+	Relief that I am not alone, provision of hope as other people have felt this way too	30% (3)	50% (3)	38% (6)
6	+	Healing from the recapitulation of the family system	30% (3)	17% (1)	25% (4)
7	+	Receiving positive feedback from others	10% (1)	33% (2)	19% (3)

8	+	We are all equal	20% (2)	-	13% (2)
9	-	Some of the group members do not take the sessions seriously, they mess around and waste the allocated time	50% (5)	-	31% (5)
10	-	Language barrier and translation difficulties made it hard to follow the group properly	20% (2)	17% (1)	19% (3)
11	-	A patient broke the confidentiality of the group and I felt violated and upset	20% (2)	-	13% (2)

When analysing the positive experiences and outcomes of group therapy, 80% of attendees and surprisingly 83% of non-attendees reported that the group therapy sessions were a helpful, supportive, encouraging and understanding space where you never felt judged by others.

One attendee said,

"It (group therapy) was very helpful. They all are very supportive. For a newcomer to come into the group, like the way I did, they were very understanding, not pressurising and open to allow the individual to take it as he wants to take it."

Another participant mentioned,

"Groups give me a platform to express my opinions in a very safe environment without fear of being judged."

Theme 2 focussed on the many patients' (63% of the sample population) experience of gaining perspective on their problems and circumstances by hearing the stories of others.

One participant mentioned,

"It's sometimes hard to hear other people's problems. Because you are actually trying to deal with your own problems but in that respect you also gain some great perspective and it helps you see that maybe your problems aren't as bad as you thought."

In theme 3 we see that 56% of the sample found that the group therapy space was mostly seen as a forum to release pent up emotions as well as allowing themselves to feel the relief that they are not alone in their suffering.

 One non-attendee said about his group experiences,

 "It's kind of helping because I have this anger problem and when I'm angry I just get aggressive and when I'm in group I find out ..Oh! There's other people that..like..have a similar problem...and we talk and sometimes when I come to group, I'm feeling angry and when I talk I feel better because I'm sharing how I feel and when you share your emotions, you feel better."

Many attendees (70%) and some non-attendees (33%) felt that it was an educational experience when attending groups.

One attendee mentioned,

"I shared a room with a lady and she's very outspoken and very straight forward and she tells it like it is. From the group therapy I've learned that a little bit from her about how to be more assertive."

Theme 5 highlighted the feeling of relief when a patient discovers that they are not alone in their suffering and that many others have felt the way that they do. During this discovery of what Yalom (2005) terms universality the patient often starts to develop renewed hope. This feeling was reported by 30% of attendees and as much as 50% of non-attendees.

One participant had this to say,

"It's been a positive experience to learn how to talk about it through witnessing others in the group therapy process and then starting to share on your side. But the group therapy helped so much I can now speak openly and honestly about my problem. You can try to hide it but it doesn't work. After coming out of group therapy, most of us cry and you hug each other and get through it together. Some people will even pray for you. You feel better in yourself afterwards. Often when people start the groups, they don't want to open up, they are all bottled up but you can't do that! Let it all out! The group is there for you! I even made a friend!"

Personal healing and growth from the recapitulation of the family system was reported in theme 6. A quarter (25%) of the sample population reported experiencing internal comfort as a result of the familial repairing that the group offered to them.

One attendee mentioned,

"We have become like a family and we are spending that much time together. Eventhough we were strangers in the beginning. I mean when we say the farewell circle to somebody that's leaving, it's actually that impact that you've made on that person's life and the impact that you've made on their life. One of the ladies that left today, she became like a big sister to me…"

In theme 7, 19% of the sample population (10% of attendees and 33% of non-attendees) found that the group was beneficial for them as they enjoyed the process of receiving positive and helpful feedback from others.

One attendee had this to say,

"In one group that we did, you sit with a group of strangers and let them write about what they think of you; you land up getting positive feedback from total strangers. That was life changing for me."

Theme 8 highlighted the experience of the group members that we are all equal. This was a healing experience reported by 13% of the sample population and 20% of attendees.

One participant said this,

"But when you actually attend group therapy it's not that (judgemental). They understand and treat you as an equal. As you know, we all have problems, it doesn't matter the age, colour, size, height, whatever. That we are all equals and we all have problems and we are all trying to work through things."

Comparatively there were far less negative comments than positive comments about the group therapy experiences and outcomes. The biggest complaint, seen in theme 9, was from the attendees (50%). They felt that some group members do not take the group therapy sessions seriously and tended to waste time.

An attendee commented,

"There are times when people make jokes where we find the 30 minutes being wasted by members of the group. If people don't see the significance of getting involved in the group therapy programme then why are they here? It's very frustrating. Those people have wasted all of our time."

In theme 10, 20% of attendees and 17% of non-attendees reported the language barrier as a negative experience where some patients speak in isiZulu/English and it isn't translated. This made it very challenging for some of the patients to follow what was happening in the sessions.

One non-attendee said,

"One thing that I do find uncomfortable is when most of the Zulu people they talk in Zulu and I don't really know what they're saying because it isn't translated. They feel the same way about English that they can't always understand."

In the final theme for this objective, 20% of attendees and thus 13% of the sample population reported that they had felt violated and upset as a group member had broken the confidentiality that is emphasised within the group therapy sessions.

"An issue in one of our sessions was with patients breaking confidentiality, when you are around people who didn't attend the group, they will ask others what you had said and what's wrong with you. I felt angry and upset."

When comparing the results of the attendees with the non-attendees interestingly both groups reported many positive experiences and outcomes (36 reports for attendees and 20 reports for non-attendees) however the attendees actually reported more (9 reports) negative comments than that of the non-attendees (1 report).

4.3.3 Motivating and Hindering Factors for Attending Group Therapy Sessions

This research question explored the factors that motivated or hindered the patient in their attendance and participation in the group therapy programme. This relates directly with the cues to action based on the Health Belief Model (Bekker, 1974).

The thematic analysis is summarised in table 4.3.3 below.

Table 4.3.3 Thematic Analysis of Motivating (+) and Hindering (-) Factors for Attending Group Therapy

#	+ or -	Theme	Attendees (n=10)	Non Attendees (n=6)	Total Sample (n=16)
1	+	I believe that group therapy works	100% (10)	100% (6)	100% (16)
2	+	You feel better afterwards	60% (6)	33% (2)	50% (8)

3	+	Fun and spending time with others	20% (2)	17% (1)	19% (3)
4	+	Getting feedback from others	10% (1)	33% (2)	19% (3)
5	+	The interesting themes of the sessions motivate me	20% (2)	-	13% (2)
6	-	Physical complaints, pain, fatigue or illness	20% (2)	100% (6)	50% (8)
7	-	Feel that the programme is boring, not applicable or sessions are too child-like	50% (5)	33% (2)	44% (7)
8	-	Difficult Logistics: Waiting to receive medication or a phone call on the public phone, no water on the premises, pass out given by their psychiatrist, groups are too early in the morning	20% (2)	50% (3)	31% (5)
9	-	Side effects of medication e.g. fatigue, dizziness, nausea	20% (2)	50% (3)	31% (5)
10	-	Language barrier: I do not understand English well	20% (2)	17% (1)	19% (3)
11	-	When the General Unit and the Addiction Unit have sessions together I don't enjoy them	30% (3)	-	19% (3)
12	-	When I'm feeling very emotional,	-	50% (3)	19% (3)

		angry or anxious, I prefer to be alone and need I some space and time to think			

All of the attendee and the non-attendees i.e. 100% reported that they believed that group therapy is a successful treatment modality which is obviously a motivating factor.

In theme 2, the patients reported the comfort of feeling better after the group therapy sessions. Half of the total sample felt this way (60% of attendees and 33% of non-attendees).

One attendee said this,

"In fact I thought that I would have been (in) a worse state but I'm actually getting much better much quicker. It (group sessions) has helped me a lot."

Another element of group therapy, seen in theme 3, is the enjoyment and fun that is experienced from spending time with other people in a secure environment. Just below a fifth (19%) of the sample population reported this as a motivating factor to attend the group sessions.

One non-attendee said,

"I enjoy the social life and interacting with other people. I'm a people's person so I like it a lot."

Theme 4 identifies that some people (19%) enjoy getting feedback from other group members and how their advice and opinions often go a long way to help you with your own situation.

"The fact that there are other people there in the group to help you, it boosts your motivation for wanting to get better and working on the specific areas that you need to improve."

In theme 5 we see that 13% of the population thus 20% of attendees were motivated by the interesting themes of the group therapy sessions and they identified that it was the described content of the group seen in a written timetable that motivated them to attend the group sessions.

A participant said,

"We have also done a few activities where we run around and have to do different activities that involved us actively doing things or asking questions or just being energised. I liked the Love Languages, the Communication one and also Self-Esteem. When I looked at the timetable they were the first ones to get my attention."

In terms of hindering factors for group therapy attendance, comparatively there were many more factors mentioned. All of the non-attendees (100%) and 20% of the non-attendees spoke of physical complaints, pain and fatigue being the major hindering factor for people not to attend group therapy sessions.

A non-attendee said,

"Sometimes I get tired in the afternoon and my back starts to hurt, then I need to miss the session to lie down and rest."

Half of the attendees and 33% of non-attendees, totalling 44% of the sample felt that the group programme can sometimes be boring or not applicable to them as seen in theme 7. Furthermore, some of the sessions felt too childlike and this discouraged patients to attend those particular sessions.

"Sometimes I find that the group sessions don't apply to me and my situation. Some of the sessions can be boring too. I'm not married and one session was just about marriage."

Theme 8 described the difficult logistics that the patients need to overcome in order to be able to attend the group sessions. According to 20% of attendees and 50% of non-attendees there were delays with receiving their medication, they were given a pass out to go to town, there was no water on the premises thus they preferred to not attend or they were waiting to see their psychiatrist.

One attendee said,

"…there have been too many issues here and too many complaints. Like little bits and pieces. I mean like yesterday we didn't have water the whole day. We couldn't even have a shower. And they didn't offer us an alternative or a solution or anything."

In theme 9, 20% of attendees and 50% of non-attendees spoke of the side effects of their prescription medication as a hindering factor. The most common side effects reported were fatigue, nausea, dizziness and digestive difficulties.

A participant mentioned,

"…after the medication has been given and then I feel tired and can't go to the group. I can't go to group if I am feeling tired. You need some time to rest and then we can focus on the classes."

In theme 10, the factor of the language barrier and difficulties with translation was again brought to attention as 19% of the total participants felt that they were unable to understand the group sessions as they cannot speak or understand English adequately.

At the clinic occasionally the general psychiatry unit patients are combined with the addiction unit patients (see theme 11), 30% of attendees felt that this was not a good decision on the part of the clinic and preferred to remain in their separate units.

One attendee mentioned

"Sometimes when we are mixed with the Addiction Unit, they will tend to misbehave. It's better that if you have a problem with Anxiety that you stick with the people with the same diagnosis. The addiction patients don't know how to behave and then it affects us negatively."

Theme 12 described how 50% of non-attendees felt that they wanted space to be alone when they were feeling emotional.

One non-attendee said,

"Sometimes, I'm just feeling like I'm angry or tired and I just don't want anyone around me, like I want my space. Yeah… I think most people just need or want to be

alone because that's how some people deal with their emotions and their problems.

They sit alone and they think about it over and over until maybe it goes away."

When comparing the attendees with the non-attendees, attendees reported positive motivating factors for group attendance 19 times, while non-attendees reported similar positive experiences 11 times.

When looking at negative or hindering factors, attendees reported a similar amount of hindering factors (16) as opposed to the no-attendees (18). From this we can assume that both groups within the sample experience hindering factors however one group (attendees) overrides them while one group (non-attendees) may be more affected by them.

4.3.4 Perceptions of Social Support

This research question intended to ascertain patient's perceptions of the social support that they receive from significant others (doctors, psychologists, family, friends etc.) regarding the attendance of group therapy and was informed by the Theory of Reasoned Action and Planned Behaviour (Ajzen & Fishbein, 1980).

The thematic analysis is summarised in table 4.3.4 below.

Table 4.3.4 Thematic Analysis of Patients Perceptions of Social Support

#	Theme	Attendees (n=10)	Non Attendees (n=6)	Total Sample (n=16)
1	Supportive of me attending group therapy	70% (7)	83% (5)	75% (12)
2	No comment but they don't mind	30% (3)	-	19% (3)
3	They do not support it or understand the reason for therapy	-	17% (1)	6% (1)

As seen in theme 1, the majority of the sample (75%) with non-attendees (83%) and attendees (73%) felt that the important people in their lives (their doctor, psychologist, family and friends) were all supportive or very supportive of them attending the group therapy programme.

They mentioned,

"…my doctor said that you need to attend because you will find out all the answers and everything that you need to know from the group therapy sessions."

"I was overwhelmed by the support that I have received! They were all very happy for me to go to the group therapy."

"They support me a lot. They encourage us to go to the group a lot. We get something from the groups so they think it is good to go to the group. You have to accept yourself as you are."

Some attendees (30%) felt that their family did not really have an opinion on their group therapy attendance as seen in theme 2.

One attendee said,

"I suppose they don't mind but they also don't really know what we do here."

In theme 3 one non-attendee (6% of the sample population) spoke about her family not understanding the need for therapy or for psychiatric intervention.

She mentioned,

"The fact that I am here is a nightmare for my family. My mother still has not accepted that I am here. It made it very difficult for me to be motivated because nobody understood what I was going though. I have learnt here that fine, ok, and good are not feelings but sadly many of my family think that this is a 'white people's disease.' "

When comparing attendees and non-attendees, it is interesting to see that eventhough 83% of non-attendees family, friends and doctors support group therapy attendance; they still chose not to attend many sessions.

4.3.5 Enhancing Attendance and Participation

The fifth and final research question aimed to understand if the participant felt that there was anything that could be done to try to encourage other/more patients to attend the group therapy programme based on Bandura's Social Cognitive Theory of 1986.

The thematic analysis is summarised in table 4.3.5 below.

Table 4.3.5 Thematic Analysis of Patients Perceptions of Enhancing Group Therapy Attendance and Participation

#	Theme	Attendees (n=10)	Non Attendees (n=6)	Total Sample (n=16)
1	Reduce group sizes and make them more homogenous (e.g. split according to age, marital status and diagnosis)	50% (5)	33% (2)	44% (7)
2	Increase information provided about group therapy	50% (5)	-	31% (5)
3	Improve the Art Therapy programme, less childlike activities and better quality art supplies and projects	20% (2)	17% (1)	19% (3)
4	More interactive and fun group sessions	10% (1)	33% (2)	19% (3)
5	Make group therapy sessions compulsory for all inpatients	20% (2)	-	13% (2)
6	Try to get staff and patients to encourage group therapy attendance	10% (1)	17% (1)	13% (2)
7	Start morning sessions after 10am	-	33% (2)	13% (2)
8	Do an initial assessment to see if the patient is suitable for group therapy	10% (1)	-	6% (1)

9	Provide a detailed explanation of the group therapy theme that are to be discussed in the session	10% (1)		6% (1)

Many patients (55% of attendees and 33% of non-attendees) felt that the group sessions had too many people in them (see theme 1). They suggested that the groups be split according to age, marital status, diagnosis and keep general psychiatry and addiction units separate at all times

One non-attendee had this to say,

"I think there should be more groups. In terms if dividing groups into smaller amounts to try to put people with similar problems together. Maybe by age or by marital status, this will make the process of the group much faster because no one will then feel bored listening to people talk about issues that do not relate to yours. Also maybe dividing by language sometimes. I think that it is really important for the clinic to understand their patients."

Theme 2 was where the participants felt that in order to improve group attendance and participation, the clinic should put together a pamphlet on group therapy where it explains how and why group therapy works as well as testimonials from past patients. Half of the attendees felt that this would be a great way to boost group therapy attendance.

 One attendee said,

"I think if you give the people like an intro or brochure when they come in to the clinic about the group sessions and how it benefits you then maybe you will have more people going to groups. It may also help to hear from people from outside who have

been in this set up before, that have been through the programme, that have seen the depths of darkness in their life.. Previous patients that can come back and give a testimony. People will think well maybe this can work for me too."

Theme 3 focusses on the Art Therapy programme and how 20% of attendees and 17% of non-attendees felt that many of the art projects were chid like and that the therapy supplies and equipment was not acceptable.

One attendee said,

"I feel that the Art programme is lacking in a lot of areas. A lot of the crafts in this programme is geared more for a child of age 5 or 6. The art sessions are also too short to get anything done also some of our art products when left to dry get stolen overnight. The equipment is poor quality and the groups also need to be better prepared for to ensure that there is available stock of beading materials, good paintbrushes etc."

Theme 4 highlighted how 19% of the sample population felt that the clinic needs to run more fun and interactive sessions while in theme 5, 20% attendees thought it may be a good idea to make the group therapy sessions compulsory for all patients. In theme 6, 13% of the sample thought that group attendance would improve if the staff and other patients were asked to encourage other patients to attend the sessions. A third (33%) of non-attendees in theme 7 mentioned that they felt that the morning group sessions should only start after 10 am in order to make allowance for the patients to all get their medication, see their doctors and then be ready for group therapy. One participant (6% of the sample) felt that it would be a good idea to do any initial assessment to see if that person was the correct candidate to attend group therapy (theme 8) and theme 9 showed the opinion of one attendee (6% of the

sample) that the group sessions should have detailed explanations as to what will be covered in which particular session.

4.4 Summary

The results chapter has highlighted the main outcomes of the entire study. The results have been categorised into broad categories using the research questions as a framework. Patients' perspectives have been presented on whether group therapy is effective, personal experiences of group therapy, hindering and motivating factors as well as perceptions of social support and recommendations to enhance attendance and participation. Through the process of thematic analysis, the themes have given a clear summary of what the data had revealed and will be discussed in the chapter to follow.

Chapter 5: Discussion and Evidence

5.1 Introduction

In the chapter to follow, we take a detailed look into the explanations for the results highlighted in the previous section. The discussion is delineated according to themes identified and later compared to the theoretical frameworks of Bekker (1974), Ajzen and Fishbein (1980) and Bandura (1986). Practical methods and approaches to enhance group therapy attendance and participation in inpatient psychiatric settings are highlighted in detail in the final section.

5.2 Demographic Details

A demographic analysis revealed that the total population was made up of majority African women aged between 31 and 40 years old with a diagnosis of Major Depressive Disorder. This indicates that the results obtained may illustrate a skewed perspective as the demographics are dominated by one classification of participant. Although, other classifications of demographic were included in the study, they only fulfil a minority of the sample.

Interestingly, recent results released by The South African Depression and Anxiety Group (SADAG) highlight the fact that depression is twice as common in women as in men (Pillay & Cassimjee, 2000) and that according to the American National Mental Health Association; the rate of depression is 50% higher in African women than in Caucasian women. Although the sample in this study was not randomised and skewed towards one demographic grouping, the results may still reflect the

experience of patients identified by previous research as being at the highest risk of depressive disorders.

When reflecting back on the literature review, Silverberg (2010) in her study titled, 'Inpatient Group Psychotherapy: Predicting Attendance and Participation' found that many demographic details did not in fact have any impact on whether a patient attended the group therapy sessions or not. These demographics included the patients': age, marital status, ethnicity, gender, socio-economic status, suicidal or homicidal ideation, psychosis (ruled out in this study by exclusion criteria) length of admission, history of prior admissions, Global Assessment of Function (GAF), substance abuse history and type of medication currently being taken. The results of this study support this stance by Silverberg (2010) and from the analysis of the demographics, very little notable difference between the attendee group and the non-attendee group were determined.

5.3 Results

5.3.1 Patients Attitudes, Opinions and Perceptions of Group Therapy

Based on the Health Belief Model (Bekker, 1974) this research question aimed to understand and explore patient's attitudes and opinions of group therapy.

The main themes that were derived from the Thematic Analysis process focussed on various types and experiences of anxiety and fear. These were seen clearly where patients reported a fear of self-revelation and judgement by others, as the nature of group therapy requires a group member to share some details of their current situation. Due to this, many people may feel ashamed of their circumstances or

behaviour and thereafter fear the judgement of the other group members. Shame is defined as 'a deeply complex self-conscious emotion characterised by an affective desire to be 'unseen' as well as the self-perception of being deeply flawed, incapable and unacceptable' (Tangney & Dearing, 2002, p.110). Research suggests that shame is inextricably bound to feelings of anxiety particularly about the negative evaluation and judgement of others (Lewis, 1986). Therefore it could be reasonable to suggest that those people who experience intense levels of shame, find relationships and intense interactions with others very difficult due to their belief about the undesirability of 'self' (Mollon, 2006). This could clearly explain the desire for non-attendees to withdraw and not attend group therapy sessions in order to hide from their shame and as an attempt to protect themselves. Withdrawal, according to Poulson (2000) is defined as 'a tendency to distance oneself from shame feelings and triggering experiences in an attempt to escape the overwhelmingly painful emotion' (p.260). However, Yalom (2005) has a differing perspective and believed that through the experience of universality within the group process, shame begins to fall away.

From a cognitive perspective, Gerald (1996) attributed fear to loss of control, the inability to make a coping response and anxiety, the sum of which usually results in feelings of helplessness. All of these are most often experienced by patients receiving inpatient psychiatric care. An understanding and sensitivity to the amount and the intensity of 'fear' and 'helplessness' which is being experienced can assist health care workers in being able to better relate to and understand their patients.

Interestingly, the attendee group reported more instances of fear (70%) as compared to the non-attendees (50%). Therefore what we can deduce is that even though the attendees verbalised experiencing various types of fear regarding group therapy, this

did not in fact negatively influence their attendance to these sessions. Eventhough the patient may be feeling shameful or scared, Yalom (1995) believes that their shame begins to diminish through the universality experienced within the group, which could cue their behaviour to attend more group sessions. From this result, we can identify that fear itself is not a sufficient hindering factor to prevent patients from attending the group sessions.

The second theme speaks of negative stereotypical portrayals of mental illness in the media or society. This brings our attention to the effect of the stigmatisation of mental illness on health seeking behaviour that eventhough the patients are aware that group therapy may be of assistance to them, they may feel too 'stigmatised' to engage in and attend to the group programme.

Stigmatisation in psychiatry involves the segregation of an individual as different to 'us' and believed to possess negative traits which has the result of people reacting negatively or discriminating against persons with mental illness (Goffman, 1986). Literature describes three interacting levels of stigma: Social (public, societal, media), Structural (institutional) and Internalised (self) stigma (Corrigan, Kerr & Knudsen, 2005). The outcome of stigmatisation is the suffering of multiple negative outcomes such as demoralisation, isolation, loneliness, impaired social adaptability, unemployment, discrimination, less willing to seek help, less willing to adhere to medication, less willing to engage in health seeking behaviours and lowered self-esteem (Corrigan & Kleinlein, 2005; Perlick, Rosenheck, Clarkin, Sirey, Salahi & Struening, 2001; Wrigley, Jackson, Judd & Komiti, 2005)

Self-stigmatisation is a process whereby the person who suffers from mental illness feels that they are less than or weaker than others without mental conditions. Internal

stigmatisation of people with various mental illnesses is a massive obstacle to recovery thereby limiting opportunities and self-esteem (Corrigan, Kerr & Knudsen, 2005).

Due to the intricate nature of stigmatisation, the inpatients at most psychiatric clinics would more than likely have experienced a combination of all three types of stigma. In addition to this, the theme suggests that patients may have been exposed to social stigma which they have internalised.

During the interviews, every single participant (both attendees and non-attendees), reported believing that group therapy was an effective therapeutic modality for treating Depression and Bipolar. Perhaps many participants may have felt that if the service (group therapy) was been offered as the major type of treatment offered at the clinic, then it must be effective. Secondly, a possible explanation is that the participants were aware that group effectiveness was being studied, and they may have felt that the researcher required or preferred them to believe that group therapy is in fact an effective therapeutic intervention. This may have introduced a social desirability bias which is common in self-reports as people will often report inaccurately in order to present themselves in the best possible light (Fisher, 1993).

Another theory to try to understand this result is to analyse it according to the theoretical frameworks used in this research study. From the perspective of the Health Belief Model (Bekker, 1974), the results indicating high levels of belief in the effectiveness of group therapy (100% of attendees and non-attendees) suggest that there was high perceived effectiveness and high perceived benefits to attending group therapy. By way of indication, this assumes that most people would be cued into the action of attending groups due to the identification of the causal relationship

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between attendance of group therapy and recovery. This leaves us with the question that if the general consensus was that participants believed that group therapy was effective, why didn't everybody attend? In his research, Bekker (1974) clearly highlights that belief alone is not enough to act, if that is true then how can we understand non-attendees behaviour?

In order for a patient not to be motivated to attend group therapy sessions, they need to feel that the perceived costs of attending group therapy are too high. When taking a closer look at costs, the 'financial' element can be ruled as not applicable due to the fact that all patients' group therapy sessions were covered by medical insurance. Therefore, the non-attendees would more than likely feel that the emotional, physical or social costs are too high to motivate their attendance.

The more recent formulation of the model by Stretcher, Champion & Rosenstock (1997) highlighted that a patients' behaviour or cues to action is often driven towards attaining a higher level of self-efficacy. Those patients with high self-efficacy and belief in their own abilities to attain their goal of recovery would more than likely be more motivated to attend the group sessions.

When analysing the results according to the Theory of Reasoned Action (Ajzen & Fishbein, 1980) the evaluation of behavioural outcomes or consequences of attending group therapy would be one of the major motivating factors to bring about actual attendance to the group therapy sessions. Then why, again is the analysis of favourable outcomes not sufficient to motivate the non-attendees to attend the group sessions? Looking at the other factors of this model, perhaps their unwillingness to comply, negative normative beliefs, low self-efficacy or poor motivation, many of

which are associated with psychiatric conditions, can be the factors that result in poor attendance.

5.3.2 Patients Perspectives of the Outcomes of Attending/Not Attending the Group Programme

The results of this research area showed an overwhelmingly high amount of positive experiences where the attendees reported 36 positive experiences and 9 negative experiences while the non-attendees reported 20 positive experiences and only 1 negative experience. This result is unexpected as it suggests that even though non-attendees reported or expected positive outcomes from group therapy, they still did not attend the groups consistently. This indicates that even if patients positively evaluate perceived benefits (Health Belief Model; Bekker, 1974) or behavioural outcomes (Theory of Reasoned Action; Ajzen & Fishbein, 1980), it is not sufficient to lead to action or in this instance, attendance to the group therapy programme.

When analysing the positive outcomes of the group therapy experiences, the data seemed to very closely mirror Yalom's therapeutic factors (2005). Table 5.3.2 below illustrates how the themes are closely interrelated with these therapeutic factors.

Table 5.3.2 Themes identified compared to Yalom's Therapeutic Factors (2005)

#	Theme	Yalom's Therapeutic Factors
1	Helpful, supportive, encouraging and understanding space where you never felt judged	Group Cohesiveness Instillation of Hope
2	Helps you to see your problem/circumstances in perspective	Universality Instillation of Hope

	as you listen to others experiences	
3	A safe forum to release and discuss pent up emotion	Catharsis Group cohesiveness
4	Educational, learn new ways of coping and get to know yourself better	Imparting of Information Interpersonal Learning
5	Relief that I am not alone, provision of hope as other people have felt this way too	Universality Instillation of hope
6	Healing from the recapitulation of the family system	The corrective recapitulation of the primary family group Group cohesiveness
7	Receiving positive feedback from others	Interpersonal Learning Instillation of Hope
8	We are all equal	Group cohesiveness Universality

From the above it can be seen that the research results from this study are supportive of and reiterate Yalom's (2005) theory of group therapy and why it is effective. The results show intriguing consistency with specific regard to the therapeutic factors.

From the table above (Table 5.3.2), the most common factors expressed were cohesiveness, universality and instillation of hope. Many participants mentioned cohesiveness was a positive experience of their group therapy participation; this

notion is supported by much of the literature on this theme (Burlingame, Fuhriman & Johnson, 2002).

For many years, Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) have recognised the importance of breaking the isolation by encouraging the individual to encounter others with similar problems. The sense that their experience of pain is neither unique nor exclusive allows the person to experience the true essence and satisfaction of universality (Annis & Davis, 1991). The importance and reported experience is reiterated by the findings of this theme.

The instillation of hope also ranked highly as one of the most commonly reported therapeutic factors by participants. The results of this study therefore support the considerable theoretical and empirical evidence that hope theories enjoy in all areas of therapy (Herth, 2000).

In terms of the themes analysed, feeling understood was an important factor for many of the research participants (81% of the total sample). Research suggests that people who feel that they belong in terms of group affiliations or interpersonal relationships experienced satisfaction and well-being when they feel understood by others. Furthermore they reported greater life satisfaction and fewer physical symptoms on days in which they felt more understood by others (Lun, Kesebir & Oishi, 2009). In conjunction with understanding, the supportive nature of the group where a person did not feel judged by others was seen as the most common positive experience. Carl Rogers (1956) spoke of the problems associated with judgmental experiences and he felt that a non-judgemental attitude was central to client-centred and successful therapy. Rogers argued that patient's positive growth force was stunted from reaching its full potential in the context of judgmental others (Rogers,

1956). This research supports the importance of maintaining a non-judgemental space in the group therapy sessions in which the clients can experience growth, development and improvement.

The negative experiences reported in the study showed dissatisfaction at other patients' behaviour during the group sessions, language barriers and broken confidentiality; all of which need to be addressed and recommendations are given in the section to follow. It has been argued that language barriers often have a damaging effect on healthcare service delivery and often results in non-adherence or misdiagnosis (Flores, 2006). Flores's (2006) work goes on to identify that developing countries are not the only countries to experience language difficulties as it is also a barrier to healthcare provision in countries like the United States of America and the United Kingdom. Currently South Africa has 11 official languages and therefore, the task of providing adequately trained interpreters to assist healthcare practitioners in offering a patient with services in their first language is extremely difficult. In another study at a South African district hospital, Schlemmer (2006) reached the conclusion that language barriers in hospitals have created a significant problem for the professional and the patient as it can negatively impact on the patients' right to confidentiality as well as the patients' perspective of the quality of the healthcare service delivery.

5.3.3 Motivating and/or Hindering Factors

All of the participants in the sample (100%) reported that they believed that group therapy is effective; however this was not sufficient to motivate everyone to attend and has previously been discussed.

Interestingly, far fewer non attendees (33%) compared to attendees (60%) reported feeling better after group therapy. Group therapy can elicit difficult emotions as part of the process and possibly non-attendees could not manage this distress and therefore avoided groups as a result.

Many of the attendees explained being motivated by feeling good afterwards, the enjoyment of spending time with others, socialising, feedback offered by others and the interesting themes presented. This behaviour can be understood by the multitude of theories on motivation available. Maslow's theory on the Hierarchy of Needs (1944) and Alderfer's ERG theory (1972) give a worthy explanation as to why the participants are motivated to attend the group therapy sessions. The table below indicates how Alderfer has simplified Maslow's theories into three broader categories that more easily applied to these results.

Table 5.3.3 Table showing Alderfer's ERG theory (1972) as compared to Maslow's hierarchy of needs (1944)

Maslow	Alderfer
Self-actualisation	Growth
Self-esteem	
Social-esteem	Relatedness
Social needs	
Interpersonal security	
Physical security	Existence
Physiological needs	

According to Alderfer's theory, the patients may be attending groups in order to seek growth and relatedness to others as a way of getting their own needs or desires met. The desire for growth is satisfied by engaging in a creative and productive group activity whereby the participant feels that they are working towards improving

themselves. Similarly, the participants' desire for relatedness or belonging is satisfied through the creation of significant engagement with others in the group sessions and to be recognised and feel secure within the security of the group. These theories give a better understanding as to why the group therapy attendees are motivated to engage in the programme available to them.

When looking at the hindering factors of group attendance, all non-attendees reported physical complaints, pain, fatigue or illness as compared to only 20% of attendees. This theme seems to be one of the biggest and most notable differences between to two groups. According to Citrome and Yeomans (2005), the physical health of people with psychiatric conditions is comparatively worse than that of the general population. The relationship between mood disorders and pain is one of an intimate nature, where one can often resemble the other. Pain can be depressing and depression causes and intensifies pain (Bair, Robinson, Katon & Kroenke, 2003). People with chronic or severe pain have three times the average risk of developing psychiatric symptoms (most often mood or anxiety related) and depressed patients have three times the average risk of developing chronic pain (Bao, Sturm & Croghan, 2003). In their study, Bao, Sturm and Croghan (2003) determined that co-morbid pain amongst patients with depression is associated with increased use of general medical services and lower rates of use of mental health services. Should this research be applicable to group therapy, then physical complaints can be seen as one of the major hindering factors of patients to attending group therapy.

Bair, Robinson, Katon and Kroenke (2003) illustrated that sometimes, the very condition that one is trying to treat, may in fact be what is holding the patient back from accessing the care available to them, in this case the attendance to group

therapy sessions. Often the low energy, insomnia and hopelessness resulting from the depression or anxiety, aggravate physical pain which often makes the patient take analgesic or sleeping medication and retire to bed whenever possible (Bair et al, 2003). This behaviour is often a hindering factor to group therapy attendance at the study site.

Just under a third of the participants complained of the side-effects of medication being a major factor that hindered their group therapy attendance. According to Brambilla, Cipriani, Hotopf and Barbui (2005), more than 50% of patients who are initiated on anti-depressant treatment have one or more of the common side-effects. Common side-effects include nausea, increased appetite and weight gain, loss of sexual desire and other sexual problems, fatigue and drowsiness, insomnia, dry mouth, blurred vision, constipation, dizziness, agitation, irritability and anxiety. Many patients were also treated with anxiolytics which may have left them feeling very sedated. The experience of any of these common side effects would more than likely deter a patient from attending the group sessions.

Within the non-attendee group, 50% reported that when they are feeling emotional or angry that they prefer to be alone and take some time to think. This may suggest that patients who withdraw or use avoidant coping mechanisms may find group therapy particularly difficult to attend as attendance goes against to their normal coping mechanisms.

5.3.4 Perceptions of Social Support

The results of this section clearly indicated that the majority of attendees (70%) and non-attendees (83%) perceived that their support systems encouraged their group therapy attendance and participation. However, according to the non-attendee

group, the perception of this support was not sufficient enough to lead to group attendance. This highlights that the normative beliefs alone as seen in the Theory of Reasoned Action and Planned Behaviour (Ajzen & Fishbein, 1980) is not sufficient to bring about behavioural change or to engage in a specific behaviour, although it can determine a behavioural intention.

According to McKinlay (1974), social support networks have been found to affect the help seeking behaviour of a patient as well as to influence that person's decision to seek and maintain treatment. The results of this study challenge this as the group of non-attendees had perceived social support and the 'normative beliefs' to support their attendance to group sessions, yet they still chose not to attend. This is also supported by the research of Ilardi and Kaslow (2009) which found that perceived social support did not affect or predict the patients' group therapy attendance.

5.3.5 Enhancing Attendance and Participation

The results of this research area showed that 44% of participants felt that the groups should have fewer members and that group participants should be more homogenous with participants with similar difficulties and demographics being grouped together.

According to Gladding (1994), the ideal group has between eight and twelve members, this allows members time and space to express themselves without forming into subgroups. Maxmen (1978) found that group therapy can be effective with as few as three members and as many as fifteen, however most therapists consider eight to ten members to be the optimal size for group success. The results of this study support these recommendations suggesting that patients prefer having

smaller groups where each individual can be given time and space to process within the group therapy arena.

MacKenzie and Grabovac (2001) recommend that groups be composed heterogeneously with regard to the intricate nature of the interpersonal difficulties, but homogeneity is beneficial with regard to level of functionality. Many therapists believe that groups should comprise of heterogeneous individuals as far as possible to ensure maximal interaction with one another (Gupta, 2005). A large range of differences, including diagnostic categories, behavioural patterns, age, race, social levels and backgrounds, have been shown to be effective in relieving and rectifying interpersonal difficulties (Gupta, 2005).

Looking at gender, the literature suggests that a mix of men and women is certainly beneficial for men by increasing their interaction and engagement with the group members but may be less necessary for benefits for women (Rabinowitz, 2001). The study results seem to challenge the literature's focus on heterogeneous groups being more beneficial, suggesting that patients may prefer more homogenous groups. Group participants may have a greater sense of cohesion and experience a stronger sense of universality in homogenous groups. However, on the other hand heterogeneous groups may provide greater experiences of interpersonal learning.

Many of the participants (50% of attendees) felt the need for psychoeducation and an explanation of the group therapy process and benefits could enhance group therapy attendance. This process assists them to evaluate the behavioural outcomes which according to Ajzen & Fishbein (1980) will more than likely facilitate the engagement in that behaviour should the analysis present favourable outcomes. In terms of The Social Cognitive Theory (Bandura, 1986), the cognitive element comes

into play as the person's knowledge is increased and they have more realistic expectations as well as presented with positive outcomes, they will more than likely have the attitude that engaging in a behaviour i.e. attending groups, would be seen as beneficial to them. This also links closely with the work of Bekker (1974), that if a person evaluates the perceived benefits as positive, they would more than likely engage in that behaviour.

5.3.6 Summary of Comparison of Results with Theoretical Frameworks

When comparing the results of this study with the theoretical frameworks chosen, the following relationships can be seen:

i.   The 'perceived benefits' or belief in the effectiveness of group therapy, according to the Health Belief Model (Bekker, 1974) is *not sufficient* to lead to group therapy attendance.

ii. 'Cues to action' according to Bekker (1974) using clinic staff as the external facilitators can be seen as a *strong motivator* to group therapy attendance.

iii. With the addition to The Health Belief Model by Stretcher, Champion and Rosenstock (1997) mediating factors such as demographics and social variables *did not affect* the health seeking behaviour of the population in this study.

iv. Self-efficacy defined by Bekker (1974) and Bandura (1986) as the confidence an individual feels that she or he can successfully perform the desired behaviour is an *important indicator* of group therapy

attendance and participation. Particularly regarding physical health, side-effects of medication and shame experiences.

v.   The positive evaluation of behavioural outcomes of group attendance according to The Theory of Planned Behaviour (Ajzen & Fishbein, 1980) is *not sufficient* to lead to attendance and participation in the programme.

vi.   Positive 'subjective norms' including the perception of high levels of social support by significant people (family, friends, doctors etc.) coupled with motivation to comply was *not sufficient* in this study to lead to group therapy attendance as supported by Ilardi and Kaslow (2009).

vii. The coping strategies and the skills that a patient adopts according to Bandura (1986), whether help seeking or withdrawal, were important determinants of patients' group therapy attendance.

5.4 Summary

The chapter above discusses the results of the study. Patients' attitudes were linked to various researchers' work and theories in order to try and understand the factors affecting group attendance and non-attendance. Multiple theories were discussed however these are not seen as exhaustive explanations for the results presented.

Chapter 6: Conclusions

6.1 Introduction

The chapter to follow will discuss the significance of this study, consider its limitations, provide recommendations and suggest directions for future research.

6.2 Recommendations arising from the Study

As one of the primary aims for this study, the researcher aimed to identify ways in which to improve inpatient's attendance and participation in the group therapy programme in order to optimise and speed up their recovery process. As a result the following recommendations for the clinic arose:

i. The clinic needs to actively manage patients that are seen to be wasting time during the group sessions. Patient's that do not adhere to the group therapy rules and sabotage the group for other participants need to be asked to settle down or to leave the current session. Clear group rules need to be available in order to ensure that all parties are aware of what is expected of them which leaves little room for misinterpretation.

ii. The language barrier, particularly English and isiZulu, was reported by some participants as a negative experience as they found it difficult to understand the sessions. In order to allow these patients to be comfortable, the option of an isiZulu group or better translation needs to be explored.

iii. Two participants reported that confidentiality was broken. This difficulty needs to be handled with the utmost sensitivity and seriousness as it breaks the bond of confidence and respect that many of the sessions are bound by. Cases where confidentiality is broken should be addressed as and when they arise and the behaviour discouraged at all times.

iv. Following the guidelines that literature provides, the optimum amount of group members is between 8 and 12. Groups should aim not to exceed these numbers.

v. All of the non-attendees reported physical complaints which suggest that the clinic needs to ensure that physical complaints and side-effects of prescribed medication are managed as best as possible. This will enhance patients' attendance to the group therapy programme. It could be beneficial to have a medical practitioner on site to ensure that the patients' pain experiences coupled with the side-effects of psychiatric medication is managed as efficiently and effectively as possible.

vi. When selecting members for the various groups, the therapist should do a brief initial assessment to determine whether the patient would benefit from the group therapy program. The therapist should aim to compose groups that bring together an array of members who will both challenge and support one another while respecting and maintaining group cohesion.

vii. Through the use of pamphlets, videos or discussions, the rationale and benefits of group therapy should be clearly explained to participants who demonstrate reluctance to engage in group therapy. The better informed a

patient is about the processes and the objectives of the group, the more likely they will attend, work and remain in the group (Gupta, 2005). Evidence suggests that pre-group preparation and understanding realistic group therapy objectives is related to better group cohesion, less deviation from tasks, increased attendance, less member attrition, reduced anxiety and increased faith and belief in the success of group therapy at treating their personal difficulties (Burlingame et al, 2002).

viii.   It may be necessary to psychoeducate patients that the positive outcomes are not always immediate and that working with distressing personal material may take numerous group therapy sessions before they feel better. By empowering the patient with this knowledge, they will have more realistic perceptions of the time taken to feel the benefit of attending group sessions versus the belief in instant gratification and a speedy recovery. This should encourage patient perseverance in attending the group therapy programme.

ix.   Psychoeducation about group therapy and mental illness may also counter stereotyped media portrayal of mental health treatment and decrease the fear of the unknown, removing these barriers to engaging in treatment.

x.   When looking at stigma, the clinic could ensure that institutional stigma is kept to a minimum and also provide societal marketing and advocacy for mental illness in order to try to diminish the local community's negative stereotypes of mental illness.

xi.   By way of peer review, fellow group therapists can occasionally sit in on one another's group sessions in order to ensure that the content of the group

sessions is valid and applicable. Furthermore, this creates a mutually beneficial learning experience for both group therapists in optimising their service delivery to the mental health care user. Therapists can also be encouraged to do their own research into group therapy practices and themes and regular meetings and discussions can ensure a fresh and vibrant group therapy program that is appealing to the inpatients at the clinic.

xii. All staff should be asked to encourage inpatients to attend the group therapy programme as well as to explain and discuss the benefits. This could be aided by the clinical staff hosting a few experiential group therapy sessions for the staff that do not actively run groups. This way the staff will be able to draw on personal experience when trying to motivate a patient to attend a group therapy session.

6.3 Discussion & Significance

The literature review revealed that little research into group therapy has focussed on the patient's perspectives and opinions of group therapy and has more been focussed on therapeutic outcomes evaluated by health professionals (Morris & Schulz, 1992). Therefore the major significance of this study is that the patient's perspectives are the central core of the research thus fulfilling the knowledge gap on this theme. In this research the patient is given a voice and the researcher has incorporated their views and perspectives into the formulation of recommendations applicable to the group therapy field in South Africa. The recommendations given can be applied over a variety of clinical settings in order to not only increase group

therapy attendance and participation but also to enhance the therapeutic experience of the inpatient with psychiatric illness.

6.4 Study Limitations

A significant limitation of this study was the limited demographic diversity of the sample as the majority of the participants were African females aged 31-40 with a diagnosis of Depression. This means that the results may have provided a skewed perspective and should this study be replicated, the researcher should aim to ensure a broader diversity in the sample demographics.

Due to the nature of the sample most of the participants were expressing themselves in their second language, this is never ideal as many of the subtle nuances and deeper explanations are lost. The sample was limited to patients that were English proficient which means that potentially valuable data was lost as the opinions of those unable to speak English was not collected. This may have limited the richness of the data.

The limited variety in diagnoses of the patients admitted to the clinic meant that only patients diagnosed with Major Depression or Bipolar Mood Disorder were included in the study. It could be very beneficial to explore a larger variety of diagnoses.

The sample size was very small which means that the outcomes of the study are only applicable to a small group. Furthermore, the fact that the two groups (attendees and non-attendees) were not the same size, made the comparison using frequencies challenging.

Due to limited finances and time constraints, the researcher herself had to conduct the interviews; this could have led to researcher bias and could be limited by

employing outside data collectors should this study be replicated. As discussed previously, social desirability is suspected to have introduced possible bias into the self-reports of the participants.

A further limitation of this study is that it was unable to definitively answer the question of why many patients did not consistently attend groups when they reportedly believed the groups would be beneficial and experienced the few group therapy sessions that they did attend as helpful, supportive and encouraging. A possible explanation is that the hindering factors such as stigma, shame, a belief in the negative stereotypical portrayals of mental illness, physical pain, fatigue and negative side effects of medication, superseded the motivating factors in non-attendees decision to participate in the group therapy programme

6.5 Recommendations for Future Research

Further study in this area would be greatly beneficial as the patient's perspectives of group therapy have been underexplored. In order to address the limitations of the current study, it is recommended that future studies should be conducted with a larger, more diverse sample of participants who should be able to express themselves in their first language. If any groups are going to be compared in future research, it is important that they are similar in size.

Furthermore, the adjustment of data collection methods could be explored to try to limit social desirability bias. For instance, it may be helpful to use anonymous questionnaires as the data collection methods or make sure that the researcher has no known affiliation to the research site whatsoever.

Further research is definitely needed to explore fully why many of the patients did not attend the group therapy sessions eventhough they reportedly found these sessions helpful, supportive and encouraging. Perhaps a study can just focus on non-attendees behaviour and their reluctance to attend a therapy that they believe to be helpful to them.

6.6 Concluding Statement

While group therapy remains one of the most popular and cost-effective treatment modalities (McDermut, Miller and Brown, 2001), much research is still required to completely understand the factors that influence attendance and participation. This study has provided an initial picture of possible factors that may hinder or encourage participation in group therapy and that encouragement, support and education has the potential to increase patient's inclination to engage with the valuable group therapy programmes that are available to them. Physical complaints still prevail as the number one hindering factor to group therapy attendance and perhaps ensuring and advocating for the benefits of what the group can provide as well a gentle, encouraging therapeutic manner, the patient will be inspired to endure and explore their pain in the security that the group provides.

References

Ajzen, I., Fishbein, M. (1980). Understanding attitudes and predicting social behaviour. Englewood Cliffs, Prentice Hall.

Alderfer, C. (1972). Existence, Relatedness, and Growth; Human Needs in Organizational Settings. New York: Free Press,.

American Psychiatric Association. (2000) . *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.) Washington, DC.

Annis, H., Davis, C. (1991). Relapse Prevention. *Alcohol Health & Research World.* 15(3), 204-212.

Austin, E. (1981). *Guidelines for the Developing of ContinuingEducation for Nurses* Appleton-Century-Crofts,New York

Bair, M., Robinson, R., Katon, W., Kroenke, K. (2003). Depression and pain comorbidity: a literature review. *Archives of Internal Medicine.* 163(20), 2433-2445

Bandura, A. (1986). Health Promotion by Social Cognitive Means. *Journal of Health Educational Behaviour*, 31(5), 143-164.

Bao, Y., Sturm, R., Croghan, T. (2003). A National Study of the Effect of Chronic Pain on the Use of Health Care by Depressed Persons. *Psychiatric Services.* 54(5), 693-697

Bekker, M. (1974). The Health Belief Model & Personal Health Behaviour. *Health Education Monographs,* 2(4), 324-373.

Boyatzis, R. (1998) Transforming qualitative research: thematic analysis and code development. Thousand Oaks, CA: Sage

Brambilla, P., Cipriani, A., Hotopf, M., Barbui, C. (2005). Side-effect profile of Fluoxetine in comparison with other SSRIs, tricyclic and newer antidepressants: A meta-anlysis of clinical trial data. *Pharmacopsychiatry.* 38(2), 69-77

Braun, V., Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3: 77-101.

Budman, S., Demby, A., Soldz, S., Merry, J. (1996). Time-limited group psychotherapy for patients with personality disorders: Outcomes and dropouts. *International Journal of Group Psychotherapy*. 46(3), 357-377.

Burlingame, G., Fuhriman, A., Johnson, J. (2002). Cohesion in group psychotherapy. In J. C. Norcross (Ed.). Psychotherapy relationships that work (pp. 71– 87). Oxford University Press

Burlingame, G., MacKenzie,K., Strauss, B. (2004). *Small Group Treatment: Evidence for Effectiveness and Mechanisms of Change* (5th ed.). New York: Wiley & Sons.

Burns, N., Grove, S.(2005) *The Practice of Nursing Research. Conduct, Critique and Utilization.* Fifth edition. WB Saunders, Philadelphia PA.

Butler, T., Fuhriman, A. (1983). Curative factors in group therapy: A review of the recent literature. *Small Group Behavior*. 14(2),131-142.

Cameron, C. (1996). Patient compliance: recognition of factors involved and suggestions for promoting compliance with therapeutic regimens. *Journal of Advanced Nursing, 24*(2), 244-250.

Citrome, L., Yeomans,J. (2005) Do guidelines for severe mental illness promote physical health and well-being?. *Psychopharmacology.* 19, 102-109

Cole, J., Gardener, K. (1979). Topic work with first-year secondary pupils, in: The effective use of reading (pp. 167 - 192).

Cole, M., Greene, L. (2008). A Comparative Study of Psychotherapy Groups vs. Occupational Therapy Groups for Psychotic and Borderline Inpatients. *Occupational Therapy in Mental Health*, 4(8) , 53-67.

Corrigan, P., Kerr, A., Knudsen, L. (2005) On the stigma of mental illness: Explanatory models and methods for change. *Applied Psychology.*11 (3),179- 90.

Corrigan,P., Kleinlein, P. (2005). The impact of mental illness stigma. *American Psychological Association Press.* p. 343.

Crouch, E., Bloch, S. & Wanlass, J. (1994). Therapeutic Factors: Interpersonal and Intrapersonal Mechanisms. *Handbook of Group Psychotherapy.* New York: Wiley. 269-315

Denzin, N., Norman, K., Lincoln, Y. (2005). The Sage Handbook of Qualitative Research. (3rd ed.) Thousand Oaks,CA.

DiCicco-Bloom,B., Crabtree, B. (2006). The qualitative research interview. *Medical Education.* 40 (4) 314-321.

Donovan, J., Blake,D. (1992). Patient non-compliance: deviance or reasoned decision-making?.*Social Scientific Medicine.* 34(5), 507-513

Dufault, K., Martocchio, B. (1985).Symposium on compassionate care and the dying experience. Hope: its spheres and dimensions. Nursing Clinic of North America. 20, 379-391.

Finlay,L. (2004). The Practice of Psychosocial Occupational Therapy, (3rd ed.). Cheltenham: Nelson Thornes editiorial

Fisher, R. (1925). Statistical Methods for Research Workers. Edinburgh: Oliver and Boyd.

Flores, G. (2006). Language barriers to Healthcare in the United States. *New England Journal of Medicine,* 355, 229-331.

Garcia, I., Kennett, C., Quraishi, M., Durcan, G. (2005) Acute Care 2004: A national survey of adult psychiatric wards in England. The Sainsbury Centre for Mental Health, London

Gerald, C. (1996). Theory and Practice of Counselling and Psychotherapy, (5th ed.).CA: Brooks/Cole Publishing Company

Ghebremichael, M., Hansen, N., Zhang, H. & Sikkema, K. (2006). The dose effect of a group intervention for bereaved HIV-positive individuals. *Group Dynamics: Theory Research and Practice*, 10 (3), 167-180.

Given, L. (2008). The Sage Encyclopedia of Qualitative Research Methods. Los Angeles, California: Sage Publications.

Gladding, S. (1994). Effective Group Counselling. *Education Resources Information Centre.* Retrieved October 7, 2014, from http://www.counseling.org/resources/library/ERIC%20Digests/94-02.pdf

Goffman, E. (1986). Stigma: Notes on the Management of Spoiled Identity. New York: Touchstone.

Gordon,R. (1975) *Interviewing Strategy, Techniques and Tactics. Illinois:* Dorsey Press.

Groenewald, T. (2004). A phenomenological research design illustrated. *International Journalof Qualitative Methods*, 3(1).

Guest, G., Bunce, A., Johnson, L. (2006). How Many Interviews Is Enough? An Experiment with Data Saturation and Variability. *Field Methods,* 18 (1), 59-82.

Gulliver, A., Griffiths, K., Christensen, H. (2010). Perceived barriers and facilitators to mental health-seeking in young people: a systematic review. *BMC Psychiatry,* 10 (113).

Gupta, A. (2005). Group Therapy for Psychiatric Disorders: an Introduction. Retrieved June 18, 2014, from www.psyplexus.com/mhr/group_therapy.html

Heit, E., & Rotello, C. (2010). Relations between inductive reasoning and deductive reasoning. *Journal of Experimental Psychology: Learning, Memory, and Cognition, 36*(3), 805-812. doi: 10.1037/a0018784

Herth, K. (2000). Enhancing hope in people with a first recurrence of cancer.*Journal of Advanced Nursing.* 32, 1437-1441.

Hornsey, M., Dwyer, L., Oei, T. (2007). Beyond cohesiveness: Reconceptualizing the link between group processes and outcomes in group psychotherapy. *Small Group Research*. 38(5), 567-592.

Howard,K., Kopta,S., Krause,M., Orlinsky,D. (1986). The dose-effect relationship in Psychotherapy.*American Psychologist.* 41 (2), 159-164. doi: 10.1037/0003-066X.41.2.159

Ilardi, D., Kaslow, N. (2009). Social Difficulties Influence Group Psychotherapy Adherence in Abused, Suicidal African American Women. *Journal of Clinical Psychology*. 65(12), 1300--1311

Kerr, C., Nixon, A., Wild, D. (2010). Assessing and Demonstarting Data Saturation in Qualitative Inquiry Supporting Patient-Reported Outcomes Research. *Expert Rev Pharmacoecon Outcomes Res.* 10 (30), 269-281. doi: 10.1586/erp.10.30

Koch, T., Harrington, A. (1998).Reconceptualizing rigour: the case for reflexivity. *Journal of Advanced Nursing.* 28 (4), 882-890.

Kosters, M., Burlingame,G., Nachtigall,C., Strauss,B. (2006). A meta-analytic review of the effectiveness of inpatient group psychotherapy. *Group Dynamics: Theory, Research & Practice, 10*(2), 146-163.

Lefforge, N., Donohue, B., Strada, M. (2007). Improving session attendance in mental health and substance abuse settings: A review of controlled studies.*Behaviour Therapy*. 38, 1-22.

Lewis, H. (1986). The role of shame in depression. In M. Rutter, C. E. Izard, & P. B. Read (Eds.) Depression in young people: Developmental and clinical perspectives (pp. 325–339). New York, NY:Guilford.

Lincoln, Y., Guba, E. (1985). Naturalistic Inquiry. Beverley Hills: Sage Publications.

Lim, K., Morris, J., Craik, C. (2007). Australian Occupational Therapy Journal. Inpatients' perspectives of occupational therapy in acute mental health. 54(1): 22–32

Lorentzen,S., Ruud, T., Fjeldstad, A., Høglend, P. (2013). Comparison of short- and long-term dynamic group psychotherapy: Randomised clinical trial. *The British Journal of Psychiatry*. 203(4), 280-287

Lun, J., Kesebir, S., Oishi, S. (2009). On Feeling Understood and Feeling Well: The Role of Interdependence. *National Institute of Health.* 42(6), 1623-1628

MacKenzie, K., Grabovac, A. (2001). Interpersonal Psychotherpay Group (IPT-G) for Depression. *Journal of Psychiatric Research*. 10(1), 46-51

Maslow, A (1954). *Motivation and personality*. New York, NY: Harper.

    p. 236. ISBN 0-06-041987-3.

Maxmen, J. (1978). An educative model for inpatient group therapy.*International*

    Journal of Group Psychotherapy, 28 (3), 321-338

McDermut, W., Miller, I., Brown, R. (2001). The efficacy of group psychotherapy for

    depression: a meta-anaylsis and review of the empirical research.*Clinical*

    Psychology: Science and Practice. 8(3), 98-116.

McKinlay, J. (1974). Social networks, lay consultation and help-seeking behaviour.

    Social Forces. 9, 275-292

Merriam-Webster Medical Dictionary. (2011).In *Merriam-Webster.com*.

    Retrieved October 24, 2014, from http://www.merriam-webster.com/dictionary/

Mollon, P. (2006). Shame and jealousy: The hidden turmoils. London, UK: Karnac

Morris, L., Schulz,R. (1992). Patient compliance: an overview. *Journal of Clinical*

    Pharmacy & Therapeutics, 17(5), 283-295.

Morse, J. (1991) Strategies for sampling.In Morse J (Ed) *Qualitative Nursing*

    Research. A Contemporary Dialogue.2nd edition. Sage, Newbury Park

    CA,127-145.

Morse, J. (1995). The Significance of Saturation. *Qualitative Health Research.* 5 (4), 147-149.

Nwanga, B. (2005). Do pilot studies have any value in research?, Editorial. *International Journal of Palliative Nursing,* pp. 312-312.

Oxford English Dictionary. (2000). (3rd ed.). Oxford University Press

Page, A., Hooke, G. (2009). Increased Attendance in Inpatient Group Psychotherapy Improves Patient Outcomes. *Psychiatric Services, 60*(4), 426-428.

Peat, J., Mellis, C., Williams, K. and Xuan W. (2002), *Health Science Research: A Handbook of Quantitative Methods*, London: Sage.

Perlick, D., Rosenheck, R., Clarkin, J., Sirey, J., Streuning, E. (2001). Stigma as a barrier to recovery. Adverse effects of perceives stigmas on social adaptation of persons diagnosed with bipolar affective disorder. *Psychiatry Services.* 52(3), 27-32.

Pillay, B., Cassimjee, M. (2000)..Anxiety and Depression in an Urban General Practice. *Journal of Anxiety and Depression*.3(2),4-5.

Playle, J., & Keeley, P. (1998). Non-compliance and professional power. *Journal of Advanced Nursing, 27*(2), 304-311. doi: 10.1046/j.1365-2648.1998.00530.x

Poulson, C. (2000). Shame and work. In N. Ashkanazy, C. Hartel, & W. Zerbe (Eds.), Emotions in the workplace: Research, theory, and practice (pp. 250–271). Westport, CT: Quorum Books

Rabinowitz, F. (2001). Group Therapy for Men. In G.R Brooks & G.E Goods, *The new handbook of psychotherapy and counselling with men.* Washington, DC: American Psychological Association

Richardson ,S., Dohrenwend, B., Klem, D. (1965) *Interviewing* Basic Books, New York

Rogers, C. (1956). The Necessary and Sufficient Conditions of Therapeutic Personality Change. *Consulting Psychology*. 21, 95–103

Rose, K. (1994). Unstructured and semi-structured interviewing. *Nurse Researcher* 1, 3, 23-32.

Ruane, I. (2010). Obstacles to the Utilisation of Psychological Resources in a South African township Community. *South African Journal of Psychology,* 40(2), 214-225.

Savin-Baden, M., Major, C. (2013). Qualitative Research: The Essential Guide to Theory and Practice. London: Routledge

Schlemmer, A., Mash, B. (2006). The effects of a language barrier in a South African district hospital. *South African Medical Journal,* 96, 1084 - 1087.

Shenton, A. (2004). Education for Information. London: IOS Press

Silverberg, S. (2010). *Inpatient Group Psychotherapy: Predicting Attendance and Participation.* Doctor of Philosophy, Old Dominion University, Vancouver.

Silverman, D. (1993). Interpreting qualitative data: methods for analysing talk, text, and interaction. Thousand Oaks, CA: Sage

Smyth, A., Holian, R. (1999). *The Credibility of the Researcher Who Does Research in Their Own Organisation*. Paper presented at the Association of Qualitative Research Melbourne, Australia.

Strauss, A., & Corbin, J. (1994). Grounded theory methodology: An overview. In N.K. Denzin & Y.S. Lincoln (Eds.), Handbook of qualitative research (pp.236-247). Thousand Oaks, CA: Sage.

Stretcher,V., Champion, V., Rosenstock,I. (1997). The Health Belief Model and Health Behaviour. In D.S Goodman (Ed.), Handbook of Health Behaviour Research I: Personal and Social Determinants, pp.71-91. New York: Plenum Press.

Tangney, J., Dearing, R. (2002). Shame and guilt. New York, NY: Guilford Press.

Vaismoradi, M., Turumen, H. Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study.*Nursing and Health Sciences.* 15, 398–405

Vermeire, E., Hearnshaw, H., van Rooyen, P., Denekans, J. (2010). Patient Adherance to Treatment: Three Decades of Research. A comprehensive review. *Journal of Clinical Pharmacological Therapy.* 26, 331-342

Warren, C., Kerner,T. (2005). *The Interview. Discovering Qualitative Methods: Field Research, Interviews and Analysis.* Roxbury, Los Angeles CA.

Weis, R., Speridakos, E. (2011). A Meta-Analysis of hope enhancement strategies in clinical and community settings. *Psychology of Well-Being: Theory, Research and Practice* , 1(5). doi:10.1186/2211-1522-1-5

Welman, J. C., & Kruger, S. J. (1999). Research methodology for the business and administrative sciences. Johannesburg, South Africa: International Thompson.

Wrigley, S., Jackson, H., Judd, F., Komit,i A. (2005). Role of stigma and attitudes toward help-seeking from a general practitioner for mental health problems in a rural town. *Australia & New Zealand Psychiatry.* 39:514-21.

World Health Organisation. (2003).Adherance to Long term therapies:evidence for action. Geneva:WHO.ISBN 92-4-154599-2

Yalom, I. D. (2005). *The Theory and Practice of Group Psychotherapy* (5th ed.). New

York: Basic Books.

Appendix I: Informed Consent Form

INFORMATION FOR PARTICIPATION IN RESEARCH STUDY

To Whom It May Concern

I am conducting research to try to understand and identify the factors that influence and hinder group therapy attendance and participation at Akeso Clinic. This information will be very valuable as we attempt to identify the factors that will increase group therapy attendance and use these to gently encourage future patients to take part in this valuable form of treatment. Your participation will thus benefit future patients in their pursuit of mental wellbeing.

The research involves Vicky Clark (the researcher) asking a few questions about your experience, opinions and belief about group therapy. The researcher will need to audio record these sessions for data gathering purposes. The process should not take more than 30 minutes in total. You are free to choose not to participate in this research and this decision will have no negative consequences for you, your family nor your therapeutic treatment and experience while at Akeso Clinic. In addition, you may also decide to stop participation at any time, without any effect or prejudice towards you. The information you provide will be treated confidentially and will not be disclosed to anyone. Your name will not be put onto the questionnaire or divulged in any way. Following the research the information (without your name) will be stored securely at Akeso Clinic where I work (see below), in a secure database and destroyed after 5 years.

Should you choose to participate, it is greatly appreciated.

Please fill in and sign the Declaration on the following page.

Yours sincerely,

Vicky Clark

Occupational Therapist

Akeso Clinic

Tel: (033) 346 0065

Email: vicky.c@akeso.co.za

Independent Contact Person

If you have any problems or difficulties related to this research project that cannot be resolved with the researcher you are free to contact the Head of Psychotherapy, Akeso Clinic. DYLAN EVANS   (Tel: (033) 346 0065; Email: dylanjiva@gmail.com)

INFORMED CONSENT

DECLARATION

I _____ (full name of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project. I also give consent to the audio recording of the interview which will be used for research purposes only. I understand that I am at liberty to withdraw from the project at any time, should I so desire, without any negative consequences whatsoever.

_____   _____

 SIGNATURE OF PARTICIPANT   DATE

Please feel free to contact me if you have any queries or require any further assistance.

Sincere thanks from:

Vicky Clark

Occupational Therapist

Akeso Clinic

Tel: (033) 346 0065

Email: vicky.c@akeso.co.za

Appendix II: Interview Schedule

In my letter requesting your participation in this study, I indicated to you that I am currently completing a study on the 'Factors Affecting Patient's Participation and Attendance in the Group Therapy Programme at Akeso Clinic.

Do you acknowledge that I have discussed all concerns, ethical issues etc. and that you have personally signed the informed consent letter without coercion or force?

Therefore, you have consented to this interview.

I would like to reiterate that the aim of this interview is to obtain your ideas and opinions regarding your experiences of group therapy and the group therapy programme. The information obtained will be used for research purposes only and no names of participants, personal experiences or nay identifying data will be made known in the research report.

Do you have any questions before we start the interview?

As discussed in the informed consent letter, I would like to audio record the interview in order to make sure that nothing is missed and so I can make a transcript of our interview for data analysis purposes. Do you grant me this permission?

Let's get started.

1. What were your perceptions of group therapy before your admission?

2. Now that you have experienced group therapy, what do you think of it?

3. Is it an effective way of treating people with depression/bipolar etc.? Why or why not.

4. What have been your personal experiences as a group member?

5. What have been the positive outcomes of your group therapy experience?

6. What have been the negative outcomes of your group therapy experience?

7. In your opinion, what types of things motivate people to attend groups?

8. Also, what type of things do think would discourage people from attend groups?

9. What do the important people in your life e.g. partner, family, friends, doctor, psychologist think about you attending/not attending group therapy?

10. Do you think that Akeso Clinic could do anything to improve the group therapy attendance and participation?

Examples of probes that could be used to gather more information:

➤ How long have you been attending groups?

➤ What type of groups is most helpful to you?

➤ What types of groups have been least helpful to you?

➤ Which of the therapists at Akeso have you related strongest to?

➤ Would you recommend group therapy to a family member or friend?

Appendix III: Permission Letter from Study Site

akeso
Specialised Psychiatric Clinics

19 February 2013

Permission letter

This letter serves to confirm that Vicky Clark has been given permission to use Akeso Clinic, Pietermaritzburg, as a site to conduct a research project investigating the factors affecting attendance and participation in group psychotherapy. She may conduct this research from February 2013 till December 2013 with patients who provide informed consent to participate.

Signed

Dylan Evans
COPE Manager
Clinical Psychologist

Appendix IV: Ethical Clearance Letter (BREC)

UNIVERSITY OF KWAZULU-NATAL ™
INYUVESI
YAKWAZULU-NATALI

24 June 2013

Dr. VL Clark
Department of Occupational Health
Westville Campus
University of KwaZulu-Natal

PROTOCOL: Factors affecting attendance and participation in group Psychotherapy in a private inpatient psychiatric setting. REF: BE020/13.

EXPEDITED APPLICATION

A sub-committee of the Biomedical Research Ethics Committee has considered and noted your application received on 21 January 2013.

The study was provisionally approved pending appropriate responses to queries raised. Your responses received on 10 June 2013 to queries raised on 07 June 2013 have been noted by a sub-committee of the Biomedical Research Ethics Committee. The conditions have now been met and the study is given full ethics approval and may begin as from **24 June 2013.**

This approval is valid for one year from **24 June 2013.** To ensure uninterrupted approval of this study beyond the approval expiry date, an application for recertification must be submitted to BREC on the appropriate BREC form 2-3 months before the expiry date.

Any amendments to this study, unless urgently required to ensure safety of participants, must be approved by BREC prior to implementation.

Your acceptance of this approval denotes your compliance with South African National Research Ethics Guidelines (2004), South African National Good Clinical Practice Guidelines (2006) (if applicable) and with UKZN BREC ethics requirements as contained in the UKZN BREC Terms of Reference and Standard Operating Procedures, all available at http://research.ukzn.ac.za/Research-Ethics/Biomedical-Research-Ethics.aspx.

BREC is registered with the South African National Health Research Ethics Council (REC-290408-009). BREC has US Office for Human Research Protections (OHRP) Federal-wide Assurance (FWA 678).

The sub-committee's decision will be **RATIFIED** by a full Committee at its next meeting taking place on **13 August 2013.**

We wish you well with this study. We would appreciate receiving copies of all publications arising out of this study.

Yours sincerely

Professor D.R Wassenaar
Chair: Biomedical Research Ethics Committee

Professor D Wassenaar (Chair)
Biomedical Research Ethics Committee
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Funding Campuses: ■ Edgewood ■ Howard College ■ Medical School ■ Pietermaritzburg ■ Westville

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