EXPERIENCES OF PATIENTS WITH DEPRESSION WHO ARE RECEIVING PSYCHOTHERAPY IN SELECTED PUBLIC HOSPITALS IN ETHEKWINI DISTRICT, KWAZULU-NATAL

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Date : December 2019

Declaration

This is to certify that the work is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

2 May 2020

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Signature of student Date

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Abstract

Background

Psychotherapy is one of the methods used to treat patients diagnosed with depression. Results of quantitative research on psychotherapy supported the assumption that generally, there is insignificant progress in the outcome of psychotherapy. The question of the influence of psychotherapy orientation on treatment effectiveness has been long-standing and debated. There is a gap of knowledge on the effectiveness of psychotherapy from a patient's point of view.

Aim of the study

The study aimed to explore and describe the experiences of patients with depression who are receiving psychotherapy in selected public hospitals in eThekwini District, KwaZulu-Natal (KZN), and to make recommendations to improve patients' experiences of psychotherapy.

Methodology

A qualitative research design, with a descriptive phenomenological approach, was employed in the study. The study was conducted at three different public hospitals selected at eThekwini district in KZN. A minimum of 17 participants were selected from these hospitals, using a maximum variation sampling technique. This study utilised one-on-one, semi-structured in-depth interviews, using open-ended questions to collect data from participants. Colaizzi's method of data analysis was used to identify themes.

Findings

Five themes emerged from the analysed data, namely an understanding of psychotherapy**,** benefits of psychotherapy sessions, challenges with consultation, socio-cultural taboos and beliefs and therapeutic outcomes. The findings of this study indicated that South Africa's government hospitals are still faced with the challenge of providing adequate mental health services. Nonetheless, participants

also acknowledged the positive outcomes of their experiences of psychotherapy. Participants admitted that after psychotherapy, there were behavioral and attitude changes and that they had a more positive view of life, regardless of the challenges they encountered.

Conclusion

Although the findings indicated the significant impact of undergoing psychotherapy, there is still a need to address the gap of the imbalanced ratio of psychologists to patients in South Africa. It was recommended that the Department of Health should integrate mental health into primary health care facilities to balance the shortage of psychotherapy services. Additionally, a coordinating body is needed to oversee public education in South Africa on mental health and mental disorders to reduce the stigma of seeking psychotherapy interventions.

Key words: Depression, KwaZulu-Natal, mental health, mental health practitioner, phenomenological research, psychotherapy.

Dedication

A special dedication to my Mom, Nonhlanhla Mbanjwa.

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Glossary of terms

Depression

The Diagnostic and Statistical Manual of Mental Disorders (DSM) IV defines depression as a prominent and persistent disturbance of mood (American Psychological Association [APA] 2010: 184). According to the APA, diagnostic criteria includes depressed mood and/or loss of interest or pleasure in life activities for at least 2 weeks and at least five clinical symptoms (APA 2010: 184). A major depressive disorder is associated with significant psychosocial disabilities that often have personal, economical and medical implications for individuals and their families (Hirschfeld *et al*. 2000: 270; Judd *et al.* 2000: 376).

Experiences

Client experience refers to clients' sensations, perceptions, thoughts, and feelings during, and regarding, therapy sessions (Crits-Christoph *et al*. 2013: 298).

Psychotherapy

According to APA, psychotherapy can be defined as a *"collaborative treatment between an individual and a psychologist where the psychologist uses scientifically validated procedures to help people develop healthier, more effective habits"* (APA 2006: 273). Psychotherapy refers to the treatment of mental disorders by psychological rather than medical means.

Mental health

Mental health is defined as *"the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until later life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem"* (APA 2006: 275).

Healthcare practitioner

Healthcare practitioner is a person providing health services, registered in terms of the Health Professions Act No 56 of 1974 (South Africa, Department of Health 1974: 5) to include any other appropriate disciplines as defined in the National Health Act No 61 of 2003 (South Africa, Department of Health 2003: 10).

Introject

Unconsciously adopt the ideas or attitude of others (Anon 2020).

Acronyms

Acronym	Full word/sentence
APA	American Psychological Association
CBT	Cognitive behavioural therapy
DSM	Diagnostic and Statistical Manual of Mental Disorders
IPT	Interpersonal therapy
KZN	KwaZulu-Natal
PHC	Primary health care
UK	United Kingdom
WHO	World Health Organisation
WMHS	World Mental Health Surveys

CHAPTER 1: OVERVIEW OF THE STUDY

1.1 INTRODUCTION TO THE STUDY

This chapter will explore the background of the study, the study purpose and the research that the study is trying to answer. The importance of the study as well as the framework of the dissertation will be discussed further. Developments in mental health in psychiatric epidemiology have quantified the prevalence and inevitable challenges of mental disorders, emphasizing the significant treatment gap, particularly in low and middle-income countries (Demyttenaere *et al*. 2004: 2581-2590; Stein *et al.* 2015: 178-185).

1.2 BACKGROUND TO THE STUDY

The Diagnostic and Statistical Manual of Mental Disorders (DSM) defines depression as *"a prominent and persistent disturbance of mood.* A major depressive disorder is associated with significant psychosocial disabilities that often have personal, economic and medical implications for individuals and their families (WHO 2019: 1). Depression causes loss of interest in once loved hobbies. It can contribute to a wide range of emotional and physical problems and can reduce the ability of a person to function at work and at home (Barlow *et al.* 2017: 66). At its worst, depression can lead to suicide (Anon 2019: 12).

There was great debate as to whether depression is best thought of as a mental or physical issue and by the 1950s and 60s the medical, community accepted a classification of depression into subtypes based on supposed causes of the condition. The DSM 5 in particular sets out criteria for diagnosing depression which includes presence of five or more symptoms, present during the same two-week period, which represents a change from previous functioning (Barlow *et al.* 2017: 68). Once depression is diagnosed it can be treated. The two most common types

of treatment for depression are pharmacology medication and behavioural therapy. However, about 75% of patients prefer psychotherapy over the use of medication for the treatment of depression (McHugh *et al*. 2013: 7-8).

Psychotherapy refers to the treatment of mental disorders by psychological rather than medical means. Clark *et al.* (2017: 72-145), noted the complexity of current debates on the nature of psychopathology exemplified in recent controversies regarding the revision of the DSM and International Classification of Diseases and the formulation of the research domain criteria framework (Stein 2019: 2).-The very first qualified psychologists were more central to the apartheid regime, which contributed to the challenges the field of psychology faces today. An attempt by the previous researchers to redress such challenges directed their focus on understanding psychotherapy from the psychologist perspectives.

The question of the effectiveness of psychotherapy on depression has been longstanding and debated (Lipkin 1954; Strupp, Wallach and Wogan 1964; Orlinsky and Howard 1975; Bohart and Tallaman 1999; Duncan 2010; Cooper and McLeed 2011; Wampol and Imel 2015).Studies have been exclusively conducted on evaluating patients' experiences of psychotherapy, using quantitative research studies where feedback is inevitably predetermined on a fixed set of items, limiting the responses of patients to a fixed range of scores (Horvath *et al.* 2011; Burlingame, McClendon and Alonso 2011; Swift *et al.* 2011; Elliott *et al.* 2011; and Lambert 2013).The reviewed quantitative studies included the following: the dialogue between the therapeutic alliance and psychologists (Horvath *et al.* 2011: 9); group cohesion in group therapy (Burlingame, McClendon and Alonso 2011: 110); patient preferences with regard to the therapist or treatment (Swift *et al*. 2011: 528); patient experiences of therapist interventions such as empathy (Elliott *et al*. 2011: 32); and patient perspectives on the progress of therapy (Lambert 2013: 170).

Review of literature resulting from the dialogue between the therapeutic alliance and psychologists (Horvath *et al.* 2011: 9) indicates the data from 79 studies (58 published, 21 unpublished) were aggregated using meta-analytic methods, resulting in many existing studies that link alliance to outcome. The meta-analysis results indicate that the overall therapeutic alliance-outcome relationship is mild. The specific alliance scales have sufficient accuracy for client, psychologist, and observer scores.

Furthermore, group cohesion in a group therapy study, was conducted (Burlingame, McClendon and Alonso 2011: 110). This research discusses the synthesis of the literature on using a meta-analysis of random effects to assess the magnitude of the cohesion-outcome relationship and to investigate the influence of specific group variables on this association. Forty (40) published studies were analysed and suggested a positive, moderate relationship exists between cohesion and outcome(ref). Additionally, an online survey was conducted to investigate client preferences with regard to the therapist or treatment (Swift *et al*. 2011: 528). Results of quantitative research on psychotherapy supported the assumption that there is general insignificant progress in the outcome of psychotherapy (Laska, Gurman and Wampold 2014: 467-481).

Studies exploring the patients' experiences of psychotherapy have long existed in the field of psychology. However, such studies have been infrequent. Very few studies have provided insight into patients' experiences of psychotherapy to ascertain patients' perspectives that add value to the understanding of therapy and clinical practice. Recent studies conducted on examining various aspects of patients' experiences, used an existing database of randomized trials on psychotherapy and qualitative meta-analysis. Debates on the influence of psychotherapy orientation on treatment effectiveness have been longstanding and heated. These debates focus on lists that have been generated to identify psychotherapies that have produced modest or strong evidence of their efficacy

within randomized clinical trials (Levitt *et al.* 2016: 802). For these reasons, there is a need for qualitative research to be conducted to understand psychotherapy from the patients' perspectives.

In low-and-middle-income countries, especially in South Africa, there is a huge gap in psychotherapy in mental health care, which has arisen because of a variety of non-specialized mental health professionals and the heterogeneous contexts in which psychotherapy is administered. Historic racial discrimination in South Africa has created many challenges regarding the training of psychotherapists and psychologists as well as efficacy in the practice of psychotherapy. The apartheid regime had designed psychology to be a predominantly white female profession. Currently, this has presented a challenge where white psychologists experience difficulties in mediating the socioeconomic and ethnic reality of black patients (Stein et al. 2019: 2).

Furthermore, there is a lack of South African orientated context to psychotherapy that is derived from the patients' perspectives on problematic life issues of depression. Psychotherapy has diverse historical roots and an ongoing development which surely provokes "theoretical questions". Firstly, there are questions about who is best able to deliver psychotherapy. Secondly, there are concerns about how psychotherapists can perform in environments where resources are constrained (Stein *et al.* 2019: 2). This study will focus on patients' experiences and perspectives of psychotherapy, using qualitative methodology which is not prompted or limited by the researchers' use of psychometric measures.

1.3 PROBLEM STATEMENT

In South Africa, there is a lack of qualitative studies that focus on the experiences of psychotherapy from the patient's perspectives. Although research on patients experiences of psychotherapy is ongoing, there is still a lack of qualitative studies

that focus primarily on experiences of patients with depression who are receiving psychotherapy.

Moreover, previous studies that were conducted utilized quantitative methodology. Certain researchers indicated some quantitative studies that used psychometric measures to assess patients' feedback led to some improvement to treatment (Boswell *et al.* 2015: 6). Although psychometric measures do provide an understanding of patients' experiences of the effectiveness of psychotherapy, it still presents numerous limitations. Firstly, these measures are based on standardized answers and they do not allow the patient to express their own opinions on whether psychotherapy is effective and how it can it be improved in the future.

Secondly, feedback is inadequate because it is only related to the restricted measures administered. Thirdly, self-report measures of scoring, like the Likert-type scale, may present misleading findings or assumption of uniformity across all the instruments of measurements. Therefore, the current study is predominantly qualitative, which focused on experiences of patients with depression who are receiving psychotherapy in selected public hospitals in eThekwini District, KwaZulu-Natal of psychotherapy. The findings will purely reflect patients' perspective on psychotherapy and can be utilized to develop accurate innovations to increase effectiveness and efficiency in psychotherapy.

1.4 AIM OF THE STUDY

The aim of the study was to explore and describe the experiences of patients with depression who are receiving psychotherapy in selected public hospitals in eThekwini District, KwaZulu-Natal (KZN).

1. 5 RESEARCH QUESTIONS

The study was directed by the following questions:

1.5.1 Main Research Question

- What are the experiences of patients with depression regarding psychotherapy sessions?

1.5.2 Sub-questions

- What is the understanding of the purpose of psychotherapy by patients diagnosed with depression?
- What are the opinions of patients with depression with regard to benefits of psychotherapy?
- What are the challenges faced by patients with depression during psychotherapy?
- What would alleviate the challenges to improve the experiences of patients with depression during psychotherapy?

1. 6 SIGNIFICANCE OF THE STUDY

There are many problems from the Apartheid legacy that have contributed negatively to the quality and effectiveness of psychotherapy. Since there have been a few studies investigating the experiences of patients with depression undergoing psychotherapy. It's, therefore, crucial to develop phenomenological research devoted to studying the experiences of psychotherapy from the patients' perspectives. the findings of the study can be instrumental in designing a model that will be enhancing the professional practitioner's knowledge of how psychotherapy causes psychological and behavioural improvements in the lives of patients. Particularly psychologists practising in the field, would use the findings to better equip themselves. The rationale of the study is to influence psychologist's practice on how best to adapt to existing psychotherapeutic techniques or forge new psychotherapeutic techniques and tools (Singla *et al.* 2017; Stein *et al.* 2019).

In addition, the current study will be of benefit to patients diagnosed with depression. The findings of the study will create possibilities for psychologists to implement recommendations as a result of what the participants would have said and create an improved therapeutic alliance atmosphere. Thus, psychologists will be able to engage in pro-affective psychotherapeutic counselling with depressed patients. As a result, the society will benefit and most likely the suicide rates will depreciate. It will also contribute to the actual development of therapeutic strategies and new therapeutic approaches within the South African context (Cooper and McLeod 2011; Wampold and Imel 2015).

Furthermore, the issue of suicide in South Africa is on the rise. According to the World Health Organisation (WHO 2017: 5), an estimate of approximately 800 000 people take their own lives every year, with South Africa having the sixth highest rate of suicide in Africa. Furthermore, suicide is the second leading cause of death among those aged between 15 and 29 years old (WHO 2017: 5). Thus, 79% of global suicides occur in low and middle-income countries. According to the South African Depression and Anxiety Group (SADAG n.d.) the number of calls it receives from people wanting to commit suicide is alarming and as such this poses as a real challenge in South Africa. This research is important as it can lead to customized psychotherapy strategies that aim to enhance the results of treatment. Patient experiences attending psychotherapy may also inspire other patients to attend psychotherapy sessions, diagnosed with depression and not receiving treatment.

1.7 STRUCTURE OF THE DISSERTATION

Chapter	Title	Content Description
1	Overview of the study.	This chapter presents the background to the study, problem statement, the aim of the study, research questions and significance of the study.
2	Literature review.	This chapter presents the review of literature relevant to the study.
3	Theoretical framework.	This chapter provides and explains the conceptual framework for the study.
4	Research design and methodology.	This chapter presents the research design and methods of data collection and analysis.
5	Presentation of findings.	This chapter presents the findings of the study that emerged after the process of data analysis.
6	Discussion of findings.	The chapter presents literature that either supports or refutes the findings.
7	Conclusion, limitation and recommendations of the study.	This chapter concludes the research and presents recommendations.

1. 8 SUMMARY OF THE CHAPTER

In this chapter, the introduction and background to the study, the aim of the study, the research questions and significance of the study were discussed. In Chapter 2, the literature review related to the experiences of patients diagnosed with depression who are receiving psychotherapy will be presented.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

Efron and Ravid (2018: 2) refers to the literature review as “a systematic examination of the scholarly literature about one’s topic. It critically analyses, evaluate, and synthesizes research findings, theories and practices by scholars and researchers that are related to an area of focus”. Meanwhile, Galvan and Galvan (2019: 3) states that literature review is synthesizing the primary and secondary; they are considered the primary sources of information because they are original findings of the research. This chapter will preliminary discuss the previous literature on experiences of patients with depression who are undergoing psychotherapy. This chapter beings with a discussion about the process of reviewing the literature. The discussion further moves into addressing the results of prior studies.

2.2 PROCESS OF REVIEWING THE LITERATURE

The literature review offers a framework for establishing the significance of the study and a benchmark for equating the results with other findings (Creswell and Creswell 2018: 26). A literature review can be narrowed down to a systematic process of recording previously conducted studies (Paré *et al*. 2015: 185). It is used as a tool to identify gaps in research that may exist within or under a particular phenomenon. Multiple search engines and websites, such as Google scholar, Zi-library, Science Direct, and Psychology Today were accessed to retrieve relevant literature sources related to the field of study. The following keywords were used for searching: psychotherapy; depression; patient’s experiences as well as psychodynamic theory, as well as The researcher collected relevant articles and books related to the topic, which she engaged with in order to gain insight into studies that were done in the past

regarding the research topic (Creswell and Creswell 2018: 30). As the useful literature was identified a mind map was designed.

2.3 CONTRAST BETWEEN EFFECTIVENESS AND EFFICACY OF PSYCHOTHERAPY

Effectiveness studies emphasize the external validity of the experimental design and attempt to demonstrate that the treatment can be beneficial in a typical clinical setting (Lambert and Bergin 1994: 143). Lambert and Bergin (1994: 144) state that efficacy is determined in a clinical trial or trials, in which vast variables are observed and controlled to demonstrate that the relationship between the treatment and outcome is relatively unambiguous.

Efficacy studies emphasize the internal validity of the experimental design through a variety of means including random assignment, blinding procedures for ratters, careful selection of patients, manuals to standardize treatment delivery, training and monitoring therapist adherence to the treatment, and managing the “dose” of treatment by conducting analyses that include only patients that have received a specified amount of treatment (Lambert 2013: 169). These and other strategies are used to enhance the ability of the researcher to make causal inferences based on the findings. For example, is cognitive-behavioural treatment more effective in treating panic disorder than psychodynamic treatment?

2.4 PREVIOUS STUDIES ON PSYCHOTHERAPY

Numerous studies have been conducted on psychotherapy but few have used a qualitative design. Many researchers embarked on investigating elements that were effective on the outcome of psychotherapy sessions. Nonetheless, few focused on the patients’ experiences in psychotherapy sessions. The majority of current studies conducted focus on testing specific psychotherapy techniques (Wampold and Imel 2015: 48). This research often views patients’ variability as a threat to internal validity and therefore researchers would rather avoid or try to minimize any contribution from the patients. Most researchers

often tend to quantitatively measure variables about patients such as motivation, expectations, alliances that are believed to edify patient's change. Nonetheless, few focused on the patients' experiences in psychotherapy sessions.

Patients have been identified as playing a vital key role in psychotherapy (Horvath *et al.* 2011; Burlingame *et al*. 2011; Elliott *et al*. 2011; Lambert 2010). Moreover, other clinicians (Cooper and McLeod 2011; Duncan *et al.* 2010 and Wampold and Imel 2015) had acknowledged that patients' play a vital role in contributing to a productive change. This is supported by the APA that argue that clinicians recognize that interventions will not likely be effective unless they fit in with individual's patient's characteristics, culture, and preferences (APA 2006: 273). Clinicians have endorsed the necessity of designing treatment measures that are aligned with the needs of patients and their preferences to ensure effective psychotherapy.

Although there are limited studies that identify patients as experts in psychotherapy, patients are given a voice in sharing their experiences to shed light on what they regard to be helpful or hindering in therapeutic sessions. Rogers (1961) argued that patients are the ones' who are most informative with regards to enlightening information on psychotherapy sessions. "It began to occur to me that unless I needed to demonstrate my cleverness and learning, I could do better to respond to the client about the direction of the process." (Rogers 1961 cited in Swift and Parkin 2017: 1486).

2.4.1 Epistemology on patients' experiences on psychotherapy

The initial cornerstone for qualitative research into patients' experiences in psychotherapy includes three key works, that of (Lipkin 1954; Strupp, Wallach and Wogan 1964; Orlinsky and Howard 1975). Lipkin (1954: 1-30) conducted a study that interviewed nine participants in patient-centred therapy. He arranged for patients to self-administer brief, post-session recordings, reflecting on their experience in therapy sessions with regard to both themselves and the

therapist. Post-therapy interviews gathered information on the broader experience of therapy, patients' functioning while in therapy, patients' feelings and attitude towards self, the therapist and therapy process as well as changes that were noticed.

Strupp, Wallach and Wogan (1964: 1-45) conducted a study on 44 patients and 11 therapists regarding their experiences in therapy. Patients were examined on pre-established options where 14 of the 89 questions were open-ended retrospectives accounts. The findings reported significant correlations between patients' perceptions of therapists' warmth and respect and the extent of change reported. The study indicated correlations between patients' general dissatisfaction with therapy and uncertainty about the therapist's feelings (Timulak and Keogh 2017: 557). This study only focused on the patients' dissatisfaction with therapy. Therefore, the aim of the current study was to explore the experiences of patients with depression who are undergoing psychotherapy. Furthermore, the work of Orlinsky and Howard (1975: 94) has been pivotal in this field of inquiry. Their study used a research questionnaire that invited participants to choose from a predetermined set of responses. Their findings indicated a prodigious deal of variability in patients' experiences of therapy, where some patients found therapy sessions helpful and satisfactory, and others found therapy stressful and threatening.

2.4.2 Most recent studies on patients' experiences on psychotherapy

Patients experience psychotherapy sessions differently, therefore how they reacted during therapy is often used to evaluate the effectiveness of therapy. Although there were early precursors identified by Lipkin (1954: 1-30), there has been a gradual increase in qualitative research studies looking at various aspects of patients' experiences in therapy.

Levitt (2001: 295-309), studied patients' experiences of silence in therapy sessions and found that these silences in therapy can be productive in a sense to access emotions or to articulate ideas. Throughout psychotherapy, empirical

studies explored silences by calculating the length of pauses and analysing this variable as a homogeneous element. He systematically identified and conceptualised silent moments into three categories: productive silence, neutral silence and obstructive silence. This notion is supported by Frankel and Levitt (2009: 171). Silence within psychotherapy has been investigated in previous decades by numerous researchers (Ladany *et al*. 2004; Hill *et al.* 2003; Levitt 2002; 2001). It is suggested by some researchers, that silence in therapy, may potentially hinder progress whilst, others stated, that silences in therapy may be a signal to engage in change and growth.

Furthermore, Frankel and Levitt (2009: 171-186), studied patients' experience of moments of disengagement in therapy. The study described four research areas: research on patient resistance, storytelling, secrecy, and silences have each described point in therapy during which processes of disengagement occur. Findings highlighted that storytelling was utilised by patients to avoid personal uneasiness and discomfort. Frankel and Levitt (2009: 175) also state that some patients told stories to delay talking about a disturbing subject. Secrecy was used to suppress experiences patients never intend to relive.
Knox and colleagues discussed patients' perception of the therapy termination (Knox *et al*. 2011). Findings indicated that termination of psychotherapy may be the result of either positive or negative perspectives. Termination of psychotherapy may result from a positive perspective of patients' fulfilment on the initial purpose of undergoing psychotherapy (Reis and Brown: 1999: 124). Patients generally indicated that they terminated psychotherapy because of logistics and financial reasons (Hunsley *et al*. 1999; Roe *et al.* 2006). Additionally, patients felt positive enough to terminate therapy. Most patients find that termination affected them positively; they were able to feel confident with moving on and coping with any circumstances in their life. The termination is typically planned and addressed by both psychologist and patients. As well as the expectations of self-care post-therapy, patients are given the opportunity to revisit the therapy treatment and its related growth. Both patients and their therapists freely shared their thoughts about termination (Hunsley *et al*. 1999; Roe *et al.* 2006).

Negative termination of psychotherapy resulted from harmed patients as they expressed being highly upset and devastated by their therapists. They mentioned that if they were to undergo therapy again, it would be under a different therapist. Negative termination was believed to result from the psychologist not meeting patients' expectations. Their relationships with the psychologist had positive characteristics but they revealed harmful effects, for example, patients felt untreated, emotionally scarred and unhealed (Knox *et al*. 2011: 154-167). These findings indicated that patients often ceased therapy because of an unresolved disagreement. These sentiments are similar to studies undertaken by Roe *et al*. (2006); Hunsley *et al*. (1999); Hill *et al.* (1996).

Timulak and McElvaney (2013: 131-150) conducted a meta-analysis study on seven studies that explored experiences of therapy sessions. Findings indicated two dominant insights. Firstly, empathic responding to, or interpretation of patient's statements appeared to lead to understanding and recognition of the underlying core stressors of patients' struggles or problems. Secondly, behavioural therapy resulted in patients experiencing greater progression during treatment. Psychologists who reframed events positively, supported behavioural change and empowered patients and indicated positive results. Their patients became more self-assertive. Studies that have examined in-patient process-outcome associations, have mainly focused on the alliance-outcome relationship (Falkenström *et al.* 2013; Hoffart *et al*. 2013; Zilcha-Mano 2016). The vast majority of these studies found a positive association between the alliance in one session and symptom change in the next session. That is, the better the alliance a patient reported in one session, relative to his/her average alliance scores, the more symptom change was observed in the following session.

Lambert and Shimokawa (2010) conducted a meta-analytic and mega-analytic review of a psychotherapy quality assurance system intended to enhance outcomes in patients at risk of treatment failure. Original data from six independent studies in a renowned university mental health centre and an

outpatient hospital, were re/analysed to investigate the impact of improvement input on the outcome of patients. Findings presented three forms of feedback interventions. This was the integral elements of this quality assurance system which were effective in enhancing treatment outcome, especially for signal alarm patients. Clinical support tools and the provision of patient progress feedback to therapist's feedback interventions, were also effective in preventing treatment failure

Bedi, Davis and Williams (2005) interviewed 40 patients who were undergoing psychotherapy or post-therapy regarding critical incidents that contributed to the formation or strengthening of the therapeutic alliance. They reported findings that overlapped with results from earlier studies to a significant extent, but also noted some unexpected results. In accordance with previous studies, patients identified the technical skills of the therapist, active listening skills and respect for choices, self-disclosure and validation of the patient as contributing factors to the alliance. Unanticipated findings that patients recognised as essential included therapist-behaviour that went beyond what was typical; therapist honesty, and the therapist's first impressions of the patients.

Horvath and Symonds (1991) conducted a meta-analysis based on the results of 24 studies, demonstrate the existence of a moderate but reliable association between good therapeutic alliance and a positive therapeutic outcome. More recent meta-analyses of studies examining the linkage between alliance and outcomes in both adult and youth psychotherapy (Martin, Garske and Davis 2000; Shirk and Karver 2003; Karver *et al.* 2006) have confirmed these results and have also indicated that the quality of the alliance was more predictive of a positive outcome.

2.5 GLOBAL CONTEXT OF STUDIES ON PATIENTS WITH DEPRESSION

Depression is highly prevalent with one in five people worldwide affected. However, most people with the depressive disorder do not receive treatment especially in low-and-middle-income countries, where it is estimated only 7%

to 21% of patients are treated (Cuijpers 2018: 90). In the United Kingdom (UK), access to psychotherapy for all people with depression and anxiety disorders is being actively promoted (London, Department of Health 2007: 1-84). Wedding (2007: 785-790) reviewed articles, based on an international perspective on psychotherapy, outlining the diversity in education, training, experiences and legal status of psychologists around the world and critically examining these eight countries: Argentina, Australia, Brunei, Iran, Japan, Mexico, South Africa and Spain.

According to Gomez (2007: 713-723), Argentina faced many challenges in the psychology profession, for example, psychotherapy is practised by physicians who are ill-trained. Other challenges include defining exactly who is a psychologist and the pressure of timeframe restriction on cognitive and behavioural psychotherapy (Giorgi 2009: 713-723). Kavanagh *et al*. (2007: 725-733) contradict Gomez's argument of limited timeframe of psychotherapy and state that patients are permitted to have twelve sessions of psychotherapy when they are referred by the physicians supported by a universal health care financing system. On the other hand, Australia is faced with legislative challenges regarding adequate training for anyone designated as a psychologist (Kavanagh *et al.* 2007: 725-733).

Furthermore, Kumaraswamy, a previous president of the International Society of Clinical Psychology, highlights Brunei as *"an affluent country in which beliefs about mental health disorders are profoundly influenced by the country's Muslim culture. Mental disorder is stigmatized in Brunei and mental health providers most of whom were trained in Western universities, frequently lack the cultural competence necessary to interact effectively with their Muslim Clients"* (Wedding 2007: 787). Wedding (2007: 789) was intrigued by the regulatory definition of counselling and psychotherapy that entailed educational attainment. In Iran, psychologists with doctoral degrees are eligible to practise psychotherapy and those with master's degrees are only permitted to practise counselling.

Kanazawa (2007: 755-763) described the conflict between two associations in Japan, namely the Japanese Association of Clinical Psychology and the Association of Japanese Clinical Psychology; the debate is about who is more significant from the other and holds good practice. In Mexico, psychology is categorized under the four-tiered health care system; in which psychotherapy is often the prerogative of a few personals who can afford to pay therapists.

2.6 AFRICAN CONTEXT OF STUDIES ON PATIENTS WITH DEPRESSION

There has long been interest in the epidemiology of psychiatric disorders in Africa. Two recent studies from Nigeria (Gureje *et al*. 2016: 456-471) and South Africa (Stein 2018: 112-117) have assessed the prevalence of mental disorders in Africa using representative samples. The World Mental Health Surveys (WMHS) were conducted by the World Health Organization (WHO) to evaluate the prevalence, severity, and treatment of DSM-IV mental disorders in a range of countries. The 12-month prevalence of mental disorders in Nigeria, a low-income country, was reported as 4.7% (Demyttenaere *et al.* 2004: 2581-2590).

Irrespective of the reported urgent need for treatment of mental disorders in African countries, these requests are still not met. The survey conducted in Nigeria indicates that, of the people reporting severely disabling disorders, only about 8% had received treatment in the preceding twelve months (Gureje *et al*. 2016: 456-471). In South Africa, 25.5% of people suffering from any mental disorder had received treatment in the past 12 months (Seedat *et al.* 2008: 889-897). Generally, between 76.3% to 85.4% of people in developing countries, suffering from serious disorders, do not receive treatment, compared to a range of 35.5% to 50.3% in developed countries (Demyttenaere *et al*. 2004: 2581-2590).

The WMHS data also indicate that many people who are seeking help in low- and middle-income countries are not treated with evidence-based interventions (Demyttenaere *et al.* 2004; Steyn *et al.* 2019). This healthcare deficit is due in part to resource shortages in African countries. There is a deficiency of human

resources (psychiatrists, psychologists, and other mental health professionals), a scarcity of mental health resources (psychiatric beds, diagnostic equipment, essential medicines) and inadequate financial resources (WHO 2005: para. 3 line 1). It has been estimated that Africa has 0.04 psychiatrists, 0.05 psychologists, 0.20 psychiatric nurses and 0.05 social workers per 100 000 inhabitants, compared to 11 psychiatrists, 9 psychologists, 104 psychiatric nurses and 58 social workers per 100 000 inhabitants in the UK (WHO 2005: para. 4 line 2). Most African countries have not given priority to mental health policies, resulting in half of the continent's countries not having a mental health policy at all (WHO 2005: para. 6 line 2).

As mentioned earlier, one of the causes of the treatment gap is the lack of human resources. The recruitment of mental health professionals in Africa is vastly different. According to the WHO surveys (2005: para. 6 line 4) Angola does not have any psychiatrists, psychologists, social workers and psychiatric nurses. The only mental health professionals in Malawi and Djibouti are psychiatric nurses. Equatorial Guinea only has social workers and Guinea-Bissau, only psychologists. Of the 50 African countries, 7 do not have a psychiatrist, 12 have no psychologists, 12 have no social workers and 11 have no psychiatric nurses. According to van't Hof *et al.* (2011: 35), Seychelles and South Africa appear to be best off with its mental health resources. The inequity of access to mental health care and inefficient use of available resources are other factors contributing to the gap found in the treatment of mental disorders.

2.7 SOUTH AFRICAN CONTEXT STUDIES ON PATIENTS WITH DEPRESSION

The existing psychotherapeutic models being currently utilized by mental health practitioners in South Africa, have proven relatively inappropriate and largely inaccessible to low-income population groups. This was illustrated by a study conducted within twelve months on prevalence rates of mental illness amongst South Africans (Steyn and Cilliers 2016: 2). The South African Stress and Health Study (2007) analyzed the prevalence of mental disorders from a large

pool of participants (N = 4 351) from the years 2002 to 2004 (Williams *et al.* 2007: 211-220). The study found that 35% of participants suffered from a mild anxiety disorder (of any type), 46% were classified as having a moderate mood disorder, and nearly 95% were graded as severe alcohol dependence disorder (Williams *et al.* 2007: 211-220).

Most psychotherapies have been developed in high-income Western countries in North America, Europe, and Australia. Cuijpers (2014: 90) argues that it is not well known whether psychotherapies are as effective in low-and-middle income countries. South Africa is affected by historical issues, where racial discrimination has limited services of psychotherapies and the production of psychologists to the privileged white population. According to Cooper (2017: 773), most Blacks have little access to culturally appropriate services and, *"there are currently no psychological services in rural areas"* (Pillay *et al.* 2004: 358).

The WHO (2005: para. 8 line 1) states that South Africa has only one (1) psychiatrist, eight (8) psychiatric nurses, four (4) psychologists and 20 social workers per 100,000 populations (Williams 2007: 217). There are many explanations as to why South Africans do not receive treatment for mental illness. Primarily, most individuals residing in rural areas or undeveloped communities perceive psychotherapy to be un-African and a product of colonial European hegemony (Knight 2013: 20). It is highly likely that a Black African suffering from a diagnosable mental disorder will seek the counsel of a trusted indigenous healer within the surrounding community, rather than a trained psychologist or psychiatrist (Ahmed and Pillay 2004: 121-127). Furthermore, psychotherapy is also exclusive; the cost is extremely high. The population in the low-income classed is are excluded from receiving psychotherapy as it will take half of their salary to attend one session (Ahmed and Pillay 2004: 122). These economic discrepancies are empirically racial skews. Few empirical studies are published with recent findings of a review of psychological treatments for anxiety and depression in low- and middle-income countries.

2.8 SUMMARY OF THE CHAPTER

In this chapter, a review of literature relevant to the study was presented. The literature review indicated a paucity of research on patients' perspectives of psychotherapy sessions. Chapter 3 provides and explains the conceptual framework for the study.

CHAPTER 3: THEORETICAL FRAMEWORK

3.1 INTRODUCTION

Theories are designed to describe, forecast, and clarify a phenomenon and expand existing knowledge within the boundaries of basic bounding assumptions. The theoretical framework is the structure that supports the theory of a research study (Imenda 2014; Grant and Osanloo, 2014). The theoretical framework drives the research's focus as much as it guides and shapes it. The conceptual framework provides a source of thinking, preparation and conscious action throughout the research process, helping to place the analysis in its appropriate context, defining the philosophical position of the researcher and articulating how all main methodological elements are linked (Ravitch and Riggan 2017; Ravitch and Carl 2016). This chapter explains how psychodynamic theory is utilized to facilitate understanding of depression treatment.

3.2 THEORETICAL FRAMEWORK USED AS A GUIDE

Psychological theories explain why people think, act, and feel the way they do. The most commonly used therapies are psychodynamic theory and cognitive behavioural therapy. Psychodynamic theory by Sigmund Freud was the leading school of thought within psychiatry during the first part of the 1900s. Psychodynamic theory suggests that a person must successfully resolve early developmental conflicts in order to overcome repression and achieve mental health (Phillips 2010: 173). Thus, mental illness is a failure to resolve these conflicts. Psychodynamic therapy focuses on unconscious processes as they are manifested in the client's present behaviour. Hence, the goals of psychodynamic therapy are client self-awareness and understanding of the influence of the past on present behaviour (Mintz, 2012: 11, Ackerman 2019: 2).

Psychodynamic theory was elicited to promote a better understanding of depression in order to conduct effective therapeutic sessions. The psychodynamic theories enhance individuals' knowledge and equip them on how to utilize the theory as a coping mechanism for life distresses. The theory of psychodynamics was used to explain that depression stemmed from inwardly focused rage, introjected anger following the loss of a deeply loved object or an individual and extreme super-ego demands (Freud 1917a: 120-128). This is discussed in greater depth below.

The diagram below illustrates what causes depression and how it is understood from the psychodynamic theory perspective. As Freud (1917: 128) postulated that depression may be caused by introjected anger following the loss of a deeply loved object and a person. An example from the top cubic rotating clockwise, is provided. For example, if Sipho loses his job, then it is indicated as a stressor. Stress provoked by a job loss now affects his physical health, he lacks sleep and experiences lack of concentration. As a result, his behaviour changes, he becomes socially withdrawn. Consequentially, he has negative thoughts of himself and has low self-esteem. An inward directed anger is provoked as well as self-criticism. Eventually, the repeated results in depression.

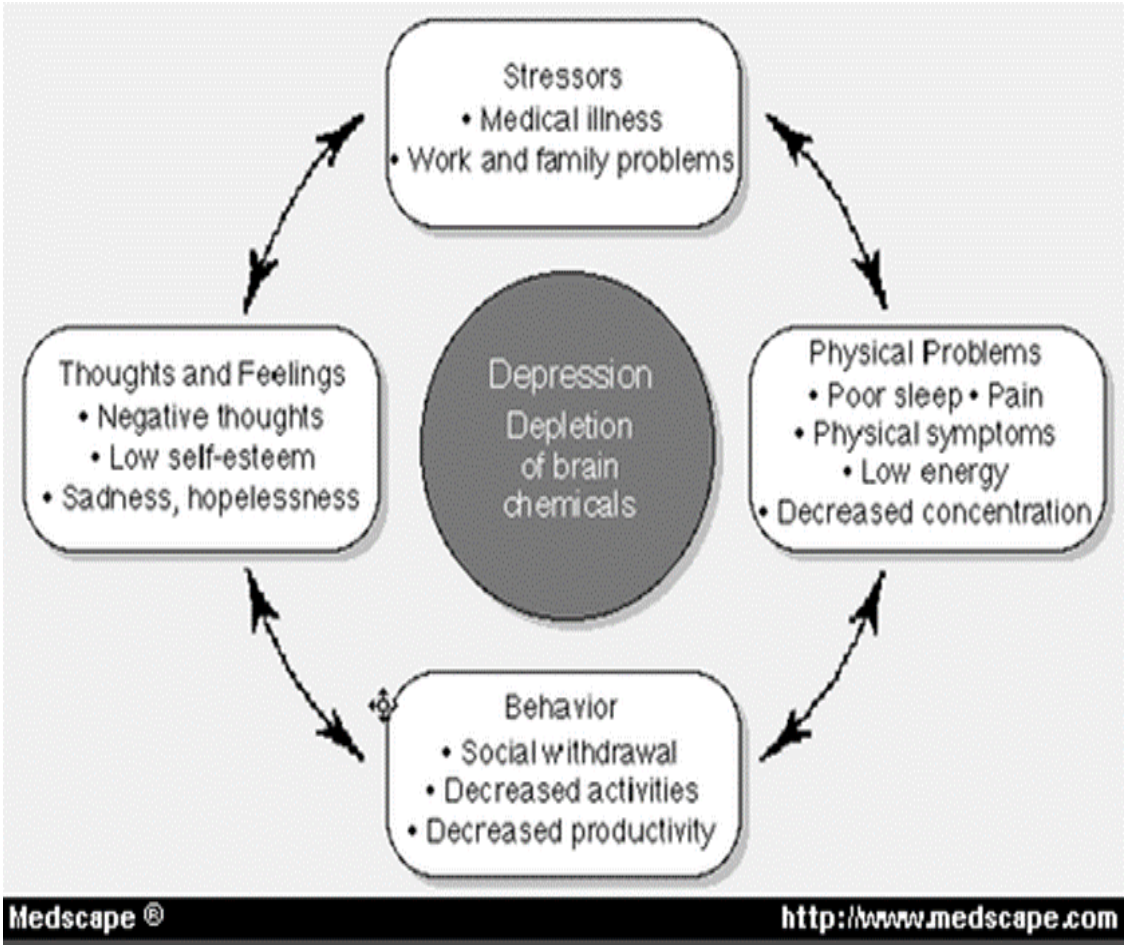

Figure 3.1: Psychodynamic Theory to illustrate how depression is understood (Anon n. d.)

3.3 CONCEPTUALIZATION OF PSYCHODYNAMIC THERAPY

Psychodynamic therapy was designed to help patients explore the full range of their emotions, including feelings they may not be aware of. Through making the subconscious aspects of their lives part of their current experiences. Psychodynamic therapy helps people understand how unresolved issues impact their actions and mood.

Psychodynamic therapy developed out of Freudian psychoanalysis ideas and methods. Psychoanalysis is based on the idea that the unconscious mind and past experiences influence the actions of an individual. Psychoanalysis requires an intense, open-ended examination of the emotions of a patient, often with multiple sessions in a week. The sessions include an analysis of the

emotions that the patient is conscious of and those that the client is unaware of before starting therapy. Psychodynamic therapy is less intense than formal psychoanalysis (Freud 1917a: 1-182).

3.4 PSYCHODYNAMIC THEORY APPLICATION IN THE STUDY

The Psychodynamic Theory guided the study. It provided guidelines on how therapy should be conducted. Initially, the primary focus was on the interrelationship of the mental, emotional, or motivational forces that interact to shape a personality (Nemade *et al*. n.d.: para 3 line 12). According to Freud (1917b: 237-258), the conscious and unconscious parts of the mind can come into conflict with one another and produce repression. Repression is a state in which you do not realize that you have some disturbing motivations, wishes or expectations, but they still have a negative influence on you. In general, psychodynamic theories suggest that a person must successfully resolve early developmental conflicts in order to overcome repression and achieve mental health. Such expectations could include gaining confidence, love, productive interpersonal relationships, and mastering functions of the body. Mental illness is a failure to resolve these conflicts (Nemade *et al*. n.d.: para 3 line 12).

Psychodynamics theory of depression has been diverse, with erratic emphases. Chodoff (1972: 666-673) highlights theoretical conceptualization of depression in terms of excessive narcissistic, oral and/or anal personality need and loss of self-esteem (Bibring 1953; Fenichel 1968). Three main themes of conceptualization emerged, namely inwardly directed anger, introjected anger following the loss of a deeply loved object and severe super-ego demands. Mudie (1978: 6) states that the themes explained, from the psychoanalytic frame of reference, depression was associated with introjected anger following the loss of an ambivalently loved object; recent ego-analytic approaches focused on loss of self-esteem associated with the inability of the ego to achieve narcissistically significant goals; the theory of object relations stressed or

emphasized failure correlated with the absence of an internalized successful goals.

The conceptual point of reference related depression to feelings of despair due to negative self, environment, and future views. According to Mathers and Loncar (2006: 442), depression will be the prevalent disease that will burden the low-income countries by the year 2030. Therefore, there is an urgent need for effective and efficient treatment for depression. Psychological therapies urgently need to constitute a predominant treatment for depressive disorders (Marcus and Olfson, 2010: 1265). Thus, this study conceptualized participants' feedback aligned to the elements of the Psychodynamic Theory as demonstrated in Figure 3.1.

3.5 SUMMARY OF THE CHAPTER

In this chapter the conceptual framework for the study was provided and explained with reference to the psychodynamic theory and the treatment of depression. Chapter 4 will present the research design and methods of data collection and analysis.

CHAPTER 4: RESEARCH DESIGN AND METHODOLOGY

4.1 INTRODUCTION

Creswell and Creswell (2018:11) defines research methodology as a logical sequence followed in a research process that includes the procedures a researcher uses to conduct a study, namely the process of data collection, analysis and synthesis of the data obtained. This chapter describes the philosophical views underpinning the study, research design, study setting, population, recruitment, sample process, data collection tool as well as data analysis.

4.2 PHILOSOPHICAL VIEWS UNDERPINNING THE STUDY

The research paradigm is characterized as a collection of fundamental assumptions and beliefs about how the world is perceived to direct the researchers' actions (Adom, Yeboah and Ankarh 2016: 1). A constructive paradigm was employed in this study to understand patients' experiences of psychotherapy. Honebein (1996 as cited in Adom, Yeboah and Ankarh 2016: 2) describes the constructivism philosophical paradigm as an approach where people construct their own understanding and knowledge of the world through experiencing things and reflecting on those experiences. Application of this paradigm allowed the researcher to explore the reality of psychotherapy experiences from the participant's perspective. The research paradigm is composed of three elements, namely ontology, epistemology and methodology (Creswell and Creswell 2018: 44).

4.2.1 Ontology

Ontology concerns itself with how individuals perceive reality, which is subjective, and dependent on social actors and their interpretation (Sundler 2019: 734). Ontology is defined by Sundler (2019: 734) as "*the study of being*". It is concerned with "*what kind of world we are investigating, with the nature of existence, with the structure of reality as such*". Kamal and Lin (2019: 1389) state that the ontological assumptions are those that respond to the question '*what is there that can be known?*' or *'what is the nature of reality?*' The study uses ontology which is essentially of a social world of meanings. In this world, researchers have to assume that the world they investigate is one populated by human beings who have their own thoughts, interpretations and meanings. The researcher's investigation of this world is clearly manifested in the use of the different research methods and techniques of the descriptive design such as interviews to describe the experiences of depression patients. These patients, who were diagnosed with depression and undergoing psychotherapy have their own unique and subjective reality. They n were the social actors in the current study.

4.2.2 Epistemology

Sundler (2019: 734) defines epistemology as a way of understanding and explaining how we know what we know. Epistemology is also concerned with providing a philosophical grounding for deciding what kinds of knowledge are possible and how we can ensure that they are both adequate and legitimate. (Sundler 2019: 734). Constructivism is defined by Christensen (2017:82) as the view of that all knowledge and therefore all meaningful reality as such is contingent upon human practices, being constructed in and out of interaction between human beings and their world and developed and transmitted within an essentially social context. Thus, meaning is not discovered but constructed. The philosophy of epistemology is concerned with ways of knowing and learning about the world and focuses on issues such as what is reality and what

forms the basis of our knowledge (van Wijngaarden, Meide and Dahlberg 2017: 1739). Participants' enquiry of knowledge is subjective. Each participant viewed psychotherapy differently.

4.2.3 Methodology

Sundler (2019: 736) define research methodology as the procedural technique executed in a research study. Methodology explains the study design, study setting, population of the study, sampling, sampling procedure, data collection methods, data collection procedure and data analysis.

4.3 RESEARCH DESIGN

Heppener *et al.* (2015: 118) define a research design as an instrument or conceptual framework that researchers utilize to arrive at a conclusion, based on scientific investigation. Creswell and Poth (2017: 5) state that a research design refers to the logical sequence that links the empirical data of the analysis to the research and finally to the conclusions. The current study employed a qualitative approach. Qualitative research addresses questions like how, when and why a social phenomenon is experienced by human beings (Creswell 2018: 41). It uses inquiry systems, rather than statistical procedures of discovering new findings on a phenomenon being researched (Cannella 2015; Dimitriadis 2016). The qualitative approach allowed the researcher to obtain richer information and better understanding regarding the lived experiences of patients with depression, receiving psychotherapy in selected public hospitals.

Christensen (2017: 82) describes Spiegelberg's six types of phenomenology, namely descriptive phenomenology, phenomenology of essence, constitutive phenomenology, reductive phenomenology, phenomenology of appearances and hermeneutical phenomenology. Phenomenology of essences includes the analysis of common themes or essences through the information and the establishment of relationship patterns expressed by particular phenomena (Van

Manen 2016: 13). Constitutive phenomenology means the phase in which things take shape in the consciousness of people as they pass from their first experiences to a complete picture of their structure (Van Manen 2016: 13).

Phenomenology of appearances involves paying attention to the ways that phenomenon appear. Hermeneutical or interpretive phenomenology concentrates on the need to study human consciousness by focussing on the world that the study participants subjectively experience Van Manen (2016: 13).

This study was guided by descriptive phenomenology in order to explore and describe the experiences of depressed patients undergoing psychotherapy. Van Manen (2016: 13) describes phenomenological research as beginning with wonder at what gives itself and how something gives itself. It can only be pursued while surrounding to a state of wonder. Thus, phenomenology refers to a person's perception(s) of the meaning of an event as opposed to the event as it exists to the person. According to Polit and Beck (2014: 272), the aim of a descriptive research design is to identify, explain and record situational aspects as they occur naturally.

4.4 DESCRIPTIVE PHENOMENOLOGY

A descriptive phenomenological approach was employed in the current study because it allowed the researcher to explore and describe the experiences of the participants' psychotherapy sessions to produce rich and in-depth data (Christensen 2017: 81). Christensen (2017: 81) defines descriptive phenomenology as direct exploration, analysis, and description of particular phenomenon, as free as possible from unexamined presuppositions, aiming at maximum intuitive presentation. Descriptive phenomenology stimulates patients' perception of lived experiences in psychotherapy, while emphasising the richness, breadth, and depth of those experiences (Christensen 2017: 81). Descriptive phenomenology is a four-step process: (1) intuiting, (2) bracketing (3) analysing and (4) describing (Christensen 2017: 81).

4.4.1 Intuiting

Intuiting is a process of thinking through the data so that a true comprehensive or accurate interpretation of what is meant in a particular description is achieved (Christensen 2017: 82). Intuiting results in a common understanding about the phenomenon under investigation (Christensen 2017: 81). The researcher developed an understanding of the experiences of patients in psychotherapy through the intuitive process. During the interviews, the researcher encouraged the creation of knowledge by using facilitative approaches such as open-ended clarification questions and avoided leading questions.

4.4.2 Bracketing

Bracketing refers to the process of holding assumptions and presuppositions in suspension to improve the rigour of the research (Sundler 2019: 736). The researcher explored her own assumptions and preconceptions in order to set them aside or keep them in suspension, rather than conceal them, so that they do not interfere with the information given by the participants. The researcher remained neutral at all times with respect to belief or disbelief in the existence of the phenomenon (Sundler 2019: 736). The researcher thus had to first identify any preconceived ideas about patients' experiences in psychotherapy. Then the researcher had to suspend any knowledge she might have about the patients' psychotherapy experiences to prevent this information from interfering with the recovery of a pure description of the phenomenon. This revealed the "truth" and determined the trustworthiness of the results.

4.4.3 Analysing

Phenomenological analysing involves identifying the essence of the phenomenon under investigation, based on the data obtained and on how the data are presented (Sundler 2019: 736). At this point, the researcher listened to, compared and contrasted descriptions of the patients' experiences of

psychotherapy. This allowed for the identification of recurring themes and interrelationships.

4.4.4 Describing

Describing was the final step and the aim was to communicate and describe (in writing and verbally) distinct, critical elements of the phenomenon, thereby communicating to others what the researcher has found (Sundler 2019: 736). The researcher avoided attempting to describe the phenomenon prematurely. Premature description is a common methodological error associated with this type of research (Sundler 2019: 736). In this study, phenomenological describing involved classifying all critical elements of essences, common to the lived experience of psychotherapy and describing these essences in detail.

4.5 THE RESEARCHER'S ROLE AND REFLEXIVITY

Creswell and Creswell (2018: 183) elicited that qualitative research involves the researcher to interpret experiences of participants. This introduce ethical and personal issues into the qualitative research process. Therefore, it is crucial for the researcher to explicitly identify reflexively her biases, principles and values background that may had shaped her interpretation formed during the study. The researcher role is to ensure that her background does not shape the direction of the study. My perception on psychotherapy has been shaped by my educational background and personal experiences. I had obtained honours degree in psychology. I have volunteered within a psychology department in one of public hospitals in eThekwini District, KZN. I bring great knowledge on the role of a psychologist in psychotherapy sessions. I have not attended psychotherapy as a patient before. Therefore, my prior knowledge does not influence the interpretation of the findings. Although I have knowledge on psychotherapy, I bring no biases to this study.

4.6 STUDY SETTING

Study setting refers to the location in which the study was conducted (Creswell and Creswell 2018: 204). Creswell and Creswell (2018: 204) states that qualitative research should be conducted in a natural setting. A natural setting is referred to as an uncontrolled real-life situation, whereby the setting is neutral and do not bring participants into a contrived situation (Creswell and Creswell 2018: 181). This research was conducted in KZN, which is one of the nine provinces in South Africa located in the southeast coast of SA (Anon 2020 para. 1 line 2). KZN is the province with the second largest population after Gauteng province (Statistics South Africa 2017: 23). The study was done in eThekwini district, the largest of the 11 districts in KZN. The eThekwini district was selected as it has all the levels of health care facilities, from Community Health Care Centres (CHCs) to the tertiary or national healthcare facilities. This study was conducted within three government public hospitals. These hospitals were selected because they had patients who were undergoing psychotherapy and met the inclusion criteria for the study.

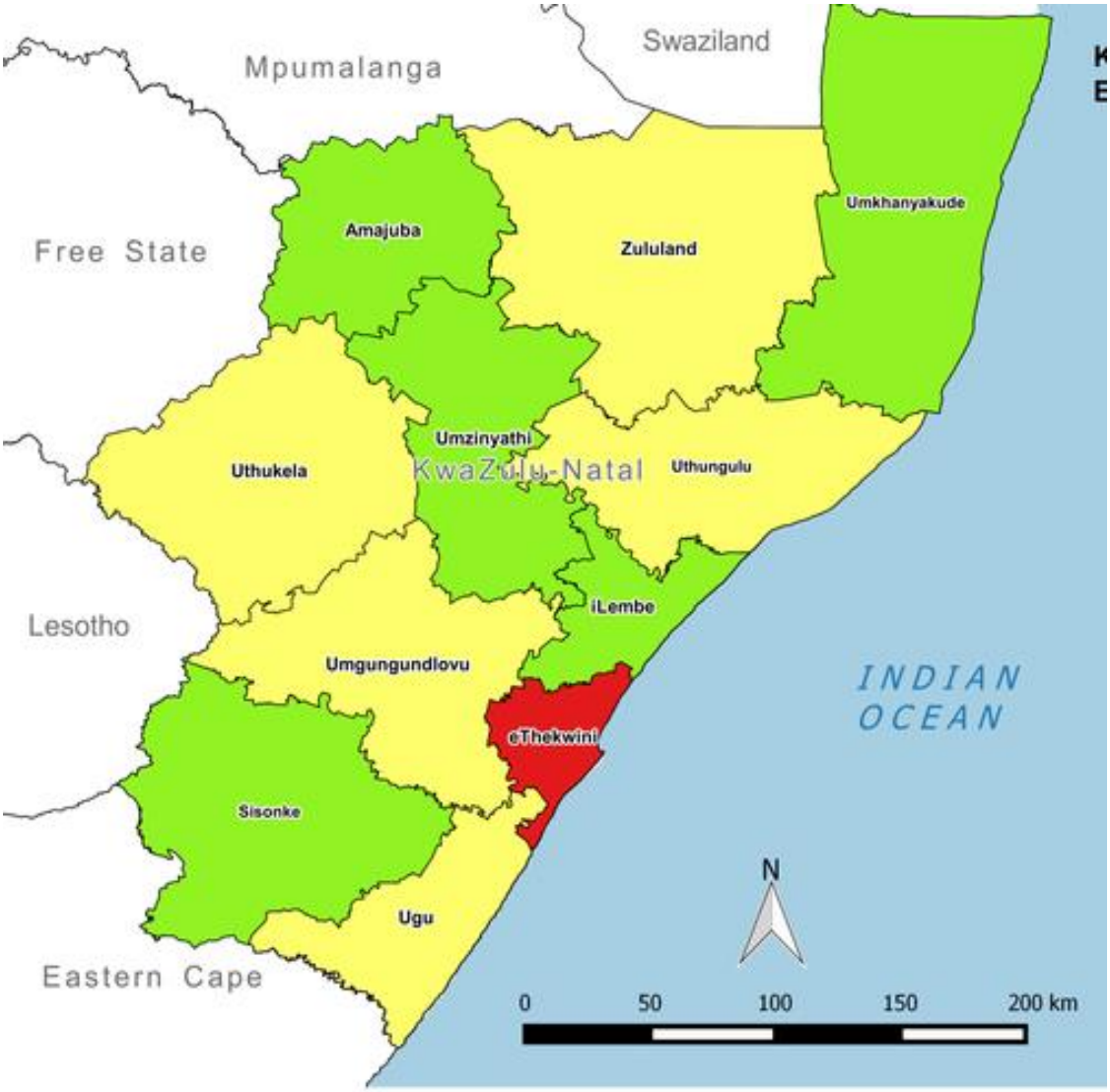

Figure 4.1: Map of KZN showing districts (Geohealth n.d.)

4.7 POPULATION

Population of the study can be defined by geography, age, sex, with additional definitions of attributes and variables such as occupation, religion and ethnicity (Majid, 2018: 5). The author also state that the study population should be defined in advance, stating unambiguous inclusion (eligibility) criteria. The study population comprised of patients who were diagnosed with depression and receiving psychotherapy. Participants were from three different hospitals; this was an attempt to get different perspectives of participants' experiences.

4.8 RECRUITMENT

Participants were recruited from the Outpatient Department (OPD) by word of mouth invitation to participate in the study. From the three Government Hospital selected. The OPD is where patients are checked for wellbeing prior to psychologist appointments. Additionally, patients exchanged knowledge about the study, so more patients would take part in the study. The prospective subjects were required to have certain characteristics to be included in the study, as identified below.

4.8.1 Inclusion criteria

- Patients diagnosed with depression and are between the ages of 18-60 years.
- Patients who were diagnosed with depression and undergoing psychotherapy.
- Patients with depression who had attended two or more psychotherapy sessions.
- Patients with depression who are from King Dinizulu Hospital, King Edward Hospital and R.K. Khan Hospital from the eThekwini district in KZN.

4.8.2 Exclusion criteria

- Patients who had not received psychotherapy.
- Patients diagnosed with intellectual disabilities and psychosis.

4.9 SAMPLING PROCESS

According to Gentles *et al.* (2015: 1772), the purpose of selecting a sample is to find elements or parts of the population that are characteristic or representative of the entire population. Sampling includes selecting groups of individuals, objects, or elements to conduct a study (Grove, Burns and Gray 2015: 249). Creswell and Creswell (2018: 262) suggest that besides the small

population number that characterizes qualitative research, the sample size depends on the use of the qualitative design. A phenomenology approach usually involves a range of 3–10 participants (Majid 2018: 5).

A maximum variation sampling was employed to pre-select the purposive participants from the general population. Maximum variation sampling, also known as heterogeneous sampling, is a technique used to capture a wide range of perspectives (Creswell 2009: 181). The rationale for the use of maximum variation sampling technique, was to get greater insight into experiences of patients in psychotherapy sessions.

Majid (2018: 6) states that sampling happens at multiple levels in qualitative research and that researchers need to determine which site will be sampled, at what point in the sampling event or phase and which participants will be sampled. The author also explains that more than one sampling strategy may be used in a single study (Majid, 2018: 6). The current study highlights the sampling strategy used to identify suitable hospitals.

4.9.1 Sampling of hospitals

In the current study, criterion sampling was used to select three hospitals located within the eThekwini District in KZN. Criterion sampling is used when the researcher intends to select cases that meet predetermined criteria (Majid 2018:5). The purpose of selecting these hospitals was to find elements or parts of the hospitals that are characteristic or representative of all the facilities. The eThekwini District has the following categories of public hospitals: district hospitals, regional hospitals, tertiary hospitals, central hospitals and specialised hospitals.

The current study selected three district hospitals out of eighteen hospitals located in the eThekwini district. The selected hospitals satisfied the predetermined criterion of having a psychology department that had patients

who were diagnosed with depression and are undergoing psychotherapy. The following inclusion criteria for hospitals were used:

4.9.1.1 Inclusion criteria for hospitals

- District hospitals in the eThekwini District.
- District hospitals that have a department of psychology.

4.9.1.2 Exclusion criteria for hospitals

- Private hospitals that have a department of psychology.
- Hospitals located outside the eThekwini district.
- Hospitals without a department of psychology.

4.10 DATA SATURATION

A total of 17 participants were sampled for this study. Data saturation occurred as the researcher interviewed the 16th and 17th participants to confirm data saturation. Charmaz (2006 cited in Creswell and Creswell 2018: 262), states that data saturation occurs when the themes get exhausted. Researchers must stop collecting data once no new data is collected; new insights are no longer ignited or new properties exposed.

4.11 DATA COLLECTION TOOL

The study utilised face-to-face, semi-structured interviews (Appendices 10a and b). The interviews involved posing open-ended questions because they are non-leading and produce authentic responses. A Zulu version of the interview guide was used to conduct interviews for those participants who were not familiar with English (Appendix 10b). The isiZulu language was chosen as the majority of the population in KZN speak isiZulu. The questions were translated into isiZulu for the none-native English-speaking participants. The participants were also asked demographic questions (Appendices 9a and 9b). Demographic information is necessary for the determination of whether the

individuals, in a particular study, are a representative sample of the target population for generalization purposes (Majid 2018: 5). The study utilized a demographic tool to provide data regarding the general characteristics of the participants such as, age, gender, level of education and marital status (Appendices 9a and b).

4.11.1 Face-to-face interview

O'Reilly and Dogra (2017: 39) defines a face-to-face interview, which is also called an in-person interview, as probably the most common and oldest form of data collection from surveys. It has remained the best method of data collection if one wants to minimize nonresponse and optimize the efficiency of the collected data. In research that can be considered very sensitive, face-to-face interviews are best methods used to request information. Interviewing is the most widely used tool to gather data in qualitative research. With technological changes in recent decades, the online interview has resolved time and financial constraints, geographical dispersion and physical mobility limitations, which have adversely affected on-site interviews.

Whereas, a focus group interview is also used as a holistic approach to gaining a detailed understanding of social problems (O'Reilly and Dogra 2017: 40). The objective of this method is to obtain data from a selected group of individuals rather than from a statistically representative sample of a larger population. Nonetheless, each of these methods offers various advantages and disadvantages and researchers should address particular contextual issues when choosing a data collection method.

4.11.1.1 Advantages of face to face interviews

Unlike postal or online methodologies, you know who completed the questionnaire with face-to-face interviews. Face-to-face interviews require the inclusion of categories of respondents who may otherwise be removed, for

example, the illiterate, the blind, the bedridden or the very elderly. In the event they believe the participants has more information, researchers will search for more information. Respondents are guided by a questionnaire one question at a time and cannot move forward or respond out of order, which may alter the findings.

4.11.1.2 Disadvantages of face to face interviews

Face-to-face interviews are intrusive, reactive and take great skill to manage without bias. Reactivity is more of a concern when it involves more than one interviewer, because it can be difficult to handle consistent reactions. Face to face interviews are costly both in terms of time and money. By their definition they need to be applied to smaller numbers than other techniques are feasible. They may run the risk of being out of date due to the lengthy periods of time that may be involved. Additionally, probing (follow-up) questions were asked (Flick 2017: 233).

4.11.2 Probing questions

The interview questions also need to include the probes. The probes are a reminder to the researcher of two types: asking for more information, or asking for an explanation of ideas (Creswell and Creswell 2018: 191). The following probing questions were used:

- Is there anything else you would like to add?
- If yes, in what way?

4.12 DATA COLLECTION PROCESS

According to Flick (2018: 7), qualitative data collection is the compilation and manufacture of linguistic (or visual) resources to examine and explain events, social areas, personal and shared interactions and related processes of meaning. The data collection process includes acquiring information from participants and following certain procedures to collect data (Creswell and

Creswell 2018: 185). In the current study, a few steps were followed to collect data. Firstly, an Ethical Clearance Certificate (IREC 099/19) from DUT Institution Research and Ethics Committee, was obtained (Appendix 1).

Additionally, before the commencement of data collection, participants received a letter of information (Appendices 7a and 7b) and consent form (Appendix 8a and 8b). The information letter provided details of the research regarding the study topic and how it will be conducted. The interview involved posing questions to in no particular order, but rather allowing the respondents to lead (Flick, 2017: 233). The interviewer indicated that the participants were allowed to withdraw at any time with no negative consequences should they feel uncomfortable. The interviewer gave a brief introduction to the session and established the purpose of the interview. The interview per-session lasted about 30-45 minutes. The interview took fifteen days to conduct although, dates were not consecutively since it was dependent on participants availability. The interview guide was utilized during the interview, written in both isiZulu and English (Appendix 10a and b). Based on the participant's preference, the interview was conducted in either English or isiZulu language.

A digital voice tape recorder was used to capture the interview discussions. The tape recorder was tested prior to the actual commence of the study. The quality of the audio feedback was evaluated and had proven to produce high quality sound. Permission was sought from the participants to use the voice recorder. Three participants requested that the voice recorder should not be used. The voice recorder was used to minimize notetaking as that could interfere with ongoing eye contact (Bolderston, 2012: 68). A verbatim written transcription of interviews was produced and the transcript was used for the Colaizzi's method of data analysis.

4.13 DATA ANALYSIS

Data analysis procedures involves segmenting and taking apart the data as well as putting it back together (Creswell and Creswell 2018: 192). According to Appelbaum *et al*. (2015: 72), the interview data demonstrates the description and interpretation of the phenomenon, and these co-exist and are complementary to each other in the process of data analysis. The interpretation of the phenomenon from the participant's perspective is taken into consideration in the data analysis process (Sundler *et al*. 2019: 736). As a result, data analysis should match the type of phenomenological study chosen for the study. In the current study, data was analysed manually. The interview data were transcribed verbatim before data analysis. Analyses began immediately after the first interview, supervisors who are expects in qualitative research checked and corrected the coding to identify themes.

In the data analysis of this study, the researcher described the experiences of patients with depression that are undergoing psychotherapy as described and perceived by the participants. Data was analysed through seven steps of Colaizzi's descriptive phenomenological method, namely familiarisation, identifying significant statements, formulating meanings, clustering themes, developing an exhaustive description producing the fundamental structure (Marrow, Rodriguez and King 2015: 643-644). The seven steps are discussed below.

4.13.1 Familiarisation

The researcher read the interview transcripts repeatedly in order to be familiar with the interview data.

4.13.2 Identifying significant statements

The researcher identified all statements in the feedback reports that were of direct relevance to the psychotherapy.

4.13.3 Formulating meanings

The researcher identified meanings, relevant to the psychotherapy experiences that arose from a careful consideration of the significant statements. The researchers explore their own assumptions and preconceptions in order to set them aside or keep them in suspension, rather than conceal them, so that they do not interfere with the information given by the participants. This is referred to as bracketing. Bracketing refers to the process of removing theories and assumptions to improve scientific rigor (Prager *et al*., 2019: 3). The researcher in the current study thus had to first identify any preconceived ideas about patients' experiences in psychotherapy (Flick 2018: 127). She had to suspend any knowledge she might have had about the patients' psychotherapy experiences to prevent this information from interfering with the recovery of a pure description of the phenomenon. This would allow the "fact" to emerge and assess the results for trustworthiness.

4.13.4 Clustering themes

Clustering includes defining the nature of the phenomena being studied, based on the data obtained and the interpretation of the data. The researcher listens to, analyses and contrasts accounts of the psychotherapy experiences of the participants. It allows recurring themes and interrelationships to be established (Flick 2018: 127).

The researcher continues to examine experiences conveyed in the data while reading. The purpose is to illuminate novel information while, keeping the aim of the study in mind. The researcher continues to explore experiences of patients with depression undergoing psychotherapy, such as how participants understood the purpose of psychotherapy and moments of engagement in psychotherapy. Thirteen subthemes were identified, see table 5.2. for detailed listing. The data sections will be illuminated further and the search for meanings and patterns will be deepened. Sundler (2019: 736) stated that it is necessary not to render definite definitions too quickly, to slow down the comprehension of data and its significances.

4.13.5 Developing an exhaustive description

The researcher writes a full and inclusive description of the phenomenon, incorporating all the themes produced at step 4 (Morrow *et al.* 2015: 643-644). The five major themes were identified, namely unconscious elements of depression, beneficial psychotherapy attendance encounters, consultation, socio-cultural taboos and beliefs of social support structure and therapeutic outcome.

4.13.6 Producing the fundamental structure

The researcher compresses the extensive explanation into a brief, concise statement covering only those elements that are considered essential to the phenomenon's structure. In this study, producing the fundamental structure involved classifying all critical elements of essences common to the lived experience of psychotherapy and describing these essences in detail Morrow et al. 2015: 643-644).

4.13.7 Seeking verification of the fundamental structure

The researcher returned the fundamental structure statements to participants to ask whether it captured their experiences (Morrow et al. 2015: 643-644).

4.14 TRUSTWORTHINESS

Anney (2015: 272-281) highlight the concept of trustworthiness by outlining the criteria of dependability, credibility, confirmability and transferability.

4.14.1 Dependability

Dependability is achieved when the same procedures, the same context and the same participants are used in a new study and similar results are generated (Anney 2015: 278). An audit trail was maintained to ensure dependability. To

achieve dependability, researchers ought to ensure that the research process is logical, accessible and clearly documented. This study outlined the research design and its implementation, describing what the plans are and how they will be executed. The operational details of data collecting were vividly stated, addressing the minutiae of what was done in the field. For the purpose of performing a comprehensive audit trail, the following records were held for the cross-check of the investigation process: raw data, interview and observation notes.

4.14.2 Credibility

Credibility addresses the question, “how congruent are findings with reality?” (Korstjens and Moser 2018: 121). Lincoln and Guba (1985 cited in Shenton 2004: 64) suggest different techniques to address credibility, including tasks such as prolonged engagements, persistent observation and data collection triangulation. This study aimed to accomplish credibility through developing an early familiarity with the culture of the participants before the first data collection interviews commenced. Furthermore, the research findings emanated from the experiences and comments of the participants and not from the researcher. Credibility was endorsed by the scrutiny of the research study by the academic supervisors who are experts in qualitative research.

4.14.2.1 Member Checking

Member checking was utilized for verification accurate data analysis. The participants served as a check throughout the analysis process. The ongoing dialogue between the researcher and participants regarding the researcher’s interpretation of the participants, reality and meaning served to ensure the truth value of data. The researcher triangulated different data sources by examining responses from the participate and used it to build a coherent justification for themes. Additionally, the researcher spends prolonged time in the field. In this duration, the researcher developed an in-depth understanding of patients’ experiences of undergoing psychotherapy.

4.14.3 Confirmability

Anney (2015: 279) state that confirmability refers to how the researcher's findings demonstrate the experiences and ideas of the participants rather than the preferences and interpretations of the researcher. In this study, the researcher provided an audit trail, showing how data collected was translated using the thematic analysis into recommendations and findings presented (Moser and Korstjens 2018:121).

4.14.4 Transferability

This refers to the degree to which the results of qualitative research can be transferred to other contexts or settings, with other participants (Moser and Korstjens 2018:121). Transferability refers to the degree to which the results can be generalised to a wider population (Anney 2015: 278). The researcher vividly outlined the research methodology used in this study to provide a detailed description so that the study could be repeated in other contexts and settings. A step by step data collection process was outlined, refer to heading 4.8. All the activities conducted during the study were described in detail and transparency was ensured throughout the study.

4.15 ETHICAL CONSIDERATIONS

There are ethical issues that need to be addressed when engaging in research, moreover, when engaging with people who have been diagnosed with depression. Ethics are moral principles that health professionals should adhere to at all times (Arifin and Roshaida 2018: 30). The study commenced once the researcher had been a granted full ethics clearance by the Durban University of Technology Institutional Research Ethics Committee (IREC Number 099/19) (Appendix 1).

It is necessary to gain access to research or archival sites by seeking approval from gatekeepers, individuals at the site who provide access to the site and

enable research to be carried out or permitted (Marshall and Rossman 2016: 32). The following steps were taken to access to the setting and to secure permission to study the participants. The following is a list of letters of permission which were sent to relevant stakeholders:

- Letter of permission to the District Manager of eThekwini Health (Appendix 2a) and an approval was obtained (Appendix 2b).
- Letter of permission to the KZN Department of Health (Appendix 3a) and an approval was obtained (Appendix 3b).
- Letter of permission to the Hospital Manager of R. K. Khan Hospital (Appendix 4a) and an approval letter was obtained (Appendix 4b).
- Letter of permission to the Hospital Manager of King Edward VIII Hospital (Appendix 5a) and an approval letter was obtained (Appendix 5b).
- Letter of permission to the Hospital Manager of King Dinizulu Hospital (Appendix 6a) and an approval letter was obtained (Appendix 6b).

The following principles of ethics will be addressed:

4.15.1 Autonomy

The study had honoured this principle by informed consent, which refers to striking a balance between over-informing and under-informing (Arifin and Rashaidai 2018: 30). Informed consent refers to a voluntary agreement to participate in research. The researcher made it mandatory to get an informed consent from the participants and not take advantage of the participants who may be vulnerable because of their condition. This was achieved by working closely with the resident psychologists at the government hospitals as well as relying on the expertise of the research supervisors to ensure that participants give informed consent for participation in the study. The informed consent forms were signed by both the participant and their respective caregiver. Furthermore, the researcher informed the participants that they have a right to withdraw from the study without suffering any negative consequences. Confidentiality at all stages of the research process, from data collection to reporting on the data,

was adhered to and with measures such as the use of pseudonyms for all names and places mentioned in the interview. Confidentiality refers to protecting the identity of the subject in research (Surmiak 2018: 1).

4.15.2 Beneficence

Beneficence is an ethical principle that addresses the idea that the researcher should do what is good for the participant. (Arifin and Rashaida 2018: 30). It is a moral obligation of the researcher to oversee the potential harmful consequences of revealing the identity of the participants. The study ensured confidentiality by using pseudonyms for all names and places mentioned in the interview.

4.15.3 Justice

Justice refers to fairness and avoiding exploitation and abuse of participants (Anney 2015: 279). Participants were selected, based on the criteria addressing the research question and not as per researcher's personal preferences, ensuring that all participants had received psychotherapy (Anney 2015: 279). Potential participants were selected, based on formal inclusion and exclusion criteria. Participation in the study was voluntary. All 17 participants were treated equally and fairly, they were asked the same questions, and every participant's response was regarded as being of equivalent significance.

4.16 SUMMARY OF THE CHAPTER

This chapter presented the research design and methods of data collection and analysis. The phenomenological methodology was outlined and the philosophical underpinnings of the research were discussed. Chapter five will present the findings of the study with reference to the themes that emerged after the process of data analysis.

CHAPTER 5: PRESENTATION OF FINDINGS

5.1 INTRODUCTION

This chapter presents the findings that were derived from the interviews conducted to understand and explore participants' experiences of undergoing psychotherapy. The raw data were analysed and thereafter clustered into relevant themes that addressed the research question of the study.

Data analysis captures the essence of what the participants communicate to the researcher (Creswell and Creswell 2018: 190 6). Commonalities in the expressed psychotherapy experiences from the participants' were clustered into five (5) themes and thirteen (13) subthemes. Data was analysed using a thematic approach which resulted in capturing dense statements, encompassing description of participants' experiences of undergoing psychotherapy (Sundler 2019: 733).

5.2 DEMOGRAPHIC DATA OF PARTICIPANTS

The researcher captured the participants' demographic information which included age, gender, marital status, level of education, and their occupation as illustrated in Table 5.1.

Table 5.1: Demographic characteristics of study sample (n=10)

P No.	Gender	Age	Marital status	Level of education	Occupation	Number of sessions
1	Female	43	Married	Grade 11	Care-giver	3
2	Female	26	Single	Honours	Unemployed	5
3	Female	28	Single	Diploma	Unemployed	4
4	Female	22	Single	Studying at a university	Student	20+
5	Female	41	Married	Diploma	Unemployed Pharmacy Assistant	12
6	Male	24	Single	Matric	Unemployed	8
7	Female	32	Single	Diploma	Educator	12
8	Male	28	Single	Matric	Unemployed	4
9	Male	36	Single	Matric	Manger (production)	5
10	Female	22	Single	Matric	Sales assistant	6
11	Female	34	Married	Honours	Human Resources	7-9
12	Female	49	Single	Diploma	Nurse	3
16	Female	29	Single	Diploma	Data capture	8
14	Female	18	Single	Grade 11	Scholar	6
15	Male	32	Single	Matric	Machine operator	6
16	Male	36	Divorced	Matric	Unemployed	4
17	Female	24	Single	N2 Certificate	Unemployed	5

Key

P No. = Participant Number

5.3 THEMES EMERGING FROM DATA ANALYSIS

Sundler (2019: 735) defines a theme as an intellectual unit that puts the participant's experience into context and gives it an identity. Five major themes were identified, namely unconscious elements of depression, beneficial

psychotherapy attendance encounters, consultation, socio-cultural taboos and beliefs of social support structure and therapeutic outcome. From data analysis, major themes were identified and listed as they emerged (Table 5.2).

Table 5.2: Emerged themes and sub-themes

Major themes	**Sub-themes**
1. An understanding of psychotherapy.	1.1 Purpose of psychotherapy. 1.2 Non-cooperation due to lack of knowledge on purpose of psychotherapy.
2. Benefits of psychotherapy sessions.	2.1 Moments of engagement in psychotherapy. 2.2 Therapeutic alliance.
3 Challenges with consultation.	3.1 Limited initial consultation time. 3.2 Challenges with bookings for appointments. 3.3 Availability of psychologists. 3.4 Psychotherapy administration in non-native language. 3.5 Judgemental and pitiful.
4 Socio-cultural taboos and beliefs.	4.1 Myths about psychotherapy. 4.2 Culture influences.
5 Therapeutic outcome.	5.1 Change of behaviour. 5.2 Development of new interpersonal skills.

5.3.1 Theme 1: An understanding of psychotherapy

When research participants were asked to clarify the purpose of psychotherapy and what psychotherapy meant for them, they responded that psychotherapy is a transformative process involving suppressed feelings and subconscious changes in behaviour. They further stated that psychotherapy reveals the

underlying issues that may result in depression. Depression is understood to be caused by the conflict of unconscious desires versus the conscious reality of an individual (Freud 1917b: 238). The following sub-themes explain participants' unconscious elements of psychotherapy.

5.3.1.1 Purpose of psychotherapy

Participants indicated that they understood psychotherapy as a process of eliciting supressed feelings. They felt worthless and expressed low self-esteem. Participants often experienced a significant loss that led to inner directed anger and grief. Some of the responses from participants listed below:

"I understand psychotherapy as counselling where I share my experiences with a psychologist hoping to feel better." (P10, female, single).

"I understood it as therapy, a way to let go of my past" (P5, female, married).

"…..Having experienced what I went through, I was so bitter and angry at myself for trusting him. Psychotherapy meant that I accept the reality and moving forward" (P13, female, single).

5.3.1.2 Non-cooperation due to lack of knowledge on purpose of psychotherapy

Participants admitted to having no knowledge on the purpose of psychotherapy. This increased the level of hindrances towards engagement in psychotherapy. Participants further reported that they were not keen to co-operate with the psychologists because they failed to understand the purpose of psychotherapy at their first session. They were of the opinion that psychologists were inquisitive. The quotes below support this statement:

"At first, I did not understand why therapists ask so many questions, they less engaging in their talks. I become resistant because I failed to understand the

purpose of therapy, yes I knew she was there to counsel me and make me feel better. Although as time goes by I gained knowledge and better understanding that the therapists was only trying to get a better feel of my situation." (P9, male, single).

"Psychologists asked too many, I believed what I was willing to share I would had informed her about it." (P8, male, single).

5.3.2 Theme 2: Benefits of psychotherapy sessions

Participants alluded that attending psychotherapy was beneficial for them. They mentioned that psychotherapy was more fruitful once they were able to develop a relationship with their psychologist.

5.3.2.1 Moments of engagement in psychotherapy.

When participants were asked what was beneficial about psychotherapy, they alluded that psychotherapy had been helpful in addressing their life stressors. Psychotherapy allowed them to share their experiences freely. They emphasized the freewill of sharing their experiences with someone they did not know. Participants commented that it is more relaxing to share your challenges with a complete stranger because it is unlikely that your issues will be discussed in public. These are their responses:

"Psychotherapy has helped me share my pain and worries that I was not able to share with anyone before." (P6, male, single).

"Sharing my experiences to a psychologist was helpful I had a chance to release everything that was bottled-up inside. A burden was removed from my shoulder" (P10, female, single).

"…mmm I must say I was very sceptical at first, I always pictured therapy as lazy psychologists seating on the coach and listening to what I had to say. With experience that wasn't the case, as time went by I got to communicate with my psychologist and now I can easy say psychotherapy is very helpful." (P16, male, divorced).

5.3.2.2 Therapeutic alliance

When participants were probed on benefits of psychotherapy, they mentioned that psychologists were always supportive and portrayed empathy. They stated that psychologists had great listening skills and were never judgemental. Psychologists were understanding and showed insight into positive thinking. The following quotes affirm this:

"Psychologists always seemed to understand what I was going through and made me to see life from a positive side. The psychologist would share how she also went through a similar experience and overcame. This gave me hope and strength to face my challenges." (P3, female, single).

"The psychologists was very understanding and listened to my problems without judging me. She was very genuine and supportive. She reassured me that things were going to all back into place and how to stay positive in the midst of challenges." (P10, female, single).

"I realised that after talking to the psychologist life wasn't that bad after all. I decided to give myself a second chance. I must admit my psychologist was very helpful." (P8, male, single).

"Being a man and sharing your troubles with a female may be very awkward but my psychologist understood be better and she had a special way of listening and responding to what I was saying, this made it easy to confound in her" (P15, male, single).

While psychotherapy may be helpful, participants reported that they are still facing challenges with the way other healthcare workers handle them during their hospitalization.

5.3.3 Theme 3: Challenges with consultation

An effective psychotherapy is time consuming and need both patients' and therapists' dedication of time. Participants expressed the following concerns: limited initial consultation time, challenges with booking for appointments and availability of psychologists.

5.3.3.1 Limited initial consultation time

Participants expressed concerns about limited time during therapy sessions. The majority of the participants alluded that 45 minutes to an hour may be too little, especially in first sessions as it is often difficult for participants to express their feelings or confide in psychologists in their first encounter. The following extracts illustrates this:

"It is difficult to open-up to a therapist you seeing for the first time, someone you do not know. Eventually you start to disclose your issues and become every emotional. By the time you start to open-up freely, time is up." (P2, female, single).

"*I was not able to disclose much in my first session with the psychologist, I felt overwhelmed and I was so sceptical about psychotherapy. She asked so many questions that I didn't have time to share what was really bothering me"* (P9, male, single).

5.3.3.2 Challenges with bookings for appointments

Most participants indicated that booking times presented several challenges. One participant reported that she did not recall appointment dates, due to memory loss. This is noted in the quotation below:

"I have a challenge when I have to rebook appointments to see the therapist after the initial appointment especially with the nurses because they make a fuss why I didn't come on booked dates. I try to explain but it very difficult because they fail to understand that I suffer from memory loss." (P1, female, married).

One participant mentioned that she had a challenge of booking an appointment directly with a psychologist. She raised a concern that she was expected to book via a nurse in the Out-Patient Department as noted in the excerpt below:

"The challenge is that you cannot just walk into the hospital and request to see a psychologist, it is not given priority attention like your psychical medical treatment." (P3, female, single).

Furthermore, one participant expressed concerns of not being able to re-book an earlier date because therapists are usually busy or either fully booked. The following quote affirms this:

"I sometime missed appointment because I didn't have transportation fee, so booking another appointment was sometimes a hustle because you often don't get the date you hoped for." (P6, male, single).

5.3.3.3 Availability of psychologists

The majority of the participants reported that therapists were not available in case of emergencies or to cater for every patient's needs. The following extracts supported this statement:

"In case of emergencies like if I have suicidal thoughts today, I cannot walk in into hospital to see therapist or psychologist unless I am hospitalised." (P4, female, single).

"There is an inadequate number of psychologists in government hospitals. Sometimes you are transferred to another hospital to see a psychologist." (P1, female, married).

"I recall one time when I wanted to see the psychologist, I was told that I needed a referral letter. I was disappointed because at that time I was really desperate to consult with a psychologist." (P11, female, married).

5.3.3.4 Psychotherapy administration in non-native language.

Participants expressed the complexities of psychotherapy being conducted in their non-native language. They mentioned that it is difficult to express yourself in a non-native language because you cannot express yourself completely and easily. Although few participants experienced such dilemma, the quotes support this challenge:

"It was a bit challenge because you take time to think more on how to distillate your thoughts as there are." (P1, female, married).

"…..the psychologist spoke in English although, for me it wasn't that much of a challenge but there are those few words when you translate to English they loss their actual meaning or essence." (P3, female, single).

5.3.3.5 Judgemental and pitiful

Participants stated that although therapists may have some level of empathy there was no empathy from heath care workers, especially for those who had been hospitalised. They reported that nurses were often judgmental and pitiful,

which is evident in their non-verbal expressions. The extracts below supported this statement:

"Nurses are judgmental, they give you that look and ill treatment because you tried to take you own life. They see us as failures and they fail to understand where we come from and our experiences, they portray us as failures." (P2, female, single).

"Other health care workers are judgemental; being around that judgmental environment is very stressful. I recall how they even looked at me with repelled eyes. Sometimes even thou they didn't say such but their facial expression was always unpleasant." (P10, female, single).

*"Although the procedural work was done properly but they were too pitiful and acted suspicious around me which then got other patients attention to be diverged towards me." (*P6, male, single).

"…people never seemed to understand why I did what I did. People are quick to be judgemental without first trying to put themselves in your shoes especially people that I have close relationships with them. My family was not able to understand what I meant when I said I'm depressed." (P3, female, single).

The above statements led to the following probing question: what are the challenges participants experience during psychotherapy?

5.3.4 Theme 4: Socio-cultural taboos and beliefs

Participants expressed that African cultures do not often embrace psychotherapy because it believed to be Western culture. They maintained that society at large often mistake depression for psychotic disorder. Respondents suggested that practising cultural beliefs posed a challenge in shaping their

decision to attend psychotherapy. The relevant sub-themes are discussed below.

5.3.4.1 Culture influences

Most participants expressed concerns that they struggled to seek psychotherapy intervention at an early stage of experiencing depression because it is not a dominant therapy in African culture. The excerpts below support this:

"For us it even more challenging because we do not believe in such things as therapy." (P5, female, married).

"Growing up, we never knew there was such thing as psychotherapy, even if we knew it wasn't going to be helpful because we were taught to never share family secretes or personal, that was regarded as a disgrace. It was a cultural norm, no outsider must know our business." (P12, female, single).

Most African participants had indicated that they were more familiar with traditional healing ways, such as seeking advice from family elders and traditional healers. The following quotes supports this:

"Psychotherapy is something new for us; growing up we only had few options to deal with depression. Back in the olden days we did not use the terminology of depression rather we referred to it as a 'troubled sprite or stresses'. I used to seek pastors counsel when face with stress." (P12, female, single).
"For us, it was even more challenging because we do not believe in such things as therapy. I usually sought advice from my late father." (P5, female, married).

5.3.4.2 Myths about psychotherapy

During probing, participants mentioned that most people think that psychotherapy was a treatment for mentally disturbed people and that depression was understood to be white people's illness. The statements below support this:

"Seeking professional help is not a bad thing at all but the stereotypes that comes with it makes it unpleasant or at unease to attend psychotherapy. Most of my friends thinks I suffer from psychotic disorder, like I am mentally challenged." (P6, male, single).

"With us native Zulu's society, we find depression to be a white people's illness even-more psychotherapy is for few rich whites. Sharing your struggles with a stranger was unlawful in my culture, we are groomed to talk to family elders when facing a life stressors." (P5, female, married).

5.3.5 Theme 5: Therapeutic outcome

When participants were probed on how they felt after psychotherapy sessions, they indicated that psychotherapy helped eliminate or monitor troublesome symptoms to enhance their ability to view life positively and promote well-being. Participants indicated that they experienced change in behaviour and development of interpersonal skills after their third session. The following sub themes support this:

5.3.5.1 Change of behaviour

Participants indicated that psychotherapy assisted them to change their behaviour especially the way they perceived life. The following extracts illustrate this:

"After my third session, I was a complete new person, I have learned to love myself more and accept things as there are." (P2, female, single).

"Psychotherapy helped me change my mind and attitude, I always looked that things from a positive perspective. Although at time I feel depressed but at least I don't have suicidal thoughts any more I just apply what I have learnt from psychologist." (P3, female, single).

"Psychotherapy thought me to love myself again, I was able to forgive myself and accept the past but I had moved away from the negative thought." (P13, female, single).

"…and here I'm all changed and I believe there is more life has to offer." (P14, female, single).

5.3.5.2 Development of new interpersonal skills

Participants stated that psychotherapy had equipped them with problem-solving skills for their future encounters. The quotations below support this statement:

"In 2017, I suffered depression again but because of the sessions I attended I was able to try contain myself from and not do anything stupid, always look at the bright side like eventually it will pass and everything will be ok. So, like every time I have an episode life it just not going well I always just try to remember the things they said like 'it won't last forever and life is more important'. They had given me skill to deal with things even-thou it happened lot time ago I can still use it now because depression is not something you have it now and you will never have it again, it's triggered by something." (P7, female, single).

"Counselling really helped me, I now know how to handle challenges when I am faced with them. I don't feel pressured anymore, I know how to do things better from a positive point of view." (P3, female, single).

5.4 SUMMARY OF THE CHAPTER

This chapter presented themes and sub-themes that emerged from the study. The researcher will discuss the findings that emerged from the themes and sub-themes in the following chapter.

CHAPTER 6: DISCUSSION OF FINDINGS

6.1 INTRODUCTION

The findings of the study which were presented according to the themes and sub-themes in the preceding chapter, will be discussed in this chapter. Analysis and interpretation were conducted, based on the experiences of patients who were diagnosed with depression and undergoing psychotherapy. The demographics of the participants will also be discussed. Discussion of the findings is guided by the objectives of the study and the Psychodynamic Theory, which was used as the theoretical framework for this study.

6.2 DEMOGRAPHICS OF PARTICIPANTS

The maximum variation sampling method was utilized to select participants who met the inclusion criteria. The inclusion criteria stipulated that participants must be between the ages of 18-60 years of age. Prerequisites were that participants ought to have attended two or more psychotherapy sessions within the three government hospitals in the eThekwini district.

6.2.1 Gender

The study reflected that 8 out of 10 of females participated in the study which indicates that more females experience depression than males. According to the SADAG in the 20% Increase in Global Depression in a Decade (Anon 2019: 5), it is estimated that quarter people suffering from depression are women. Gender is a critical determinant of mental health and mental illness. The morbidity associated with mental illness and gender is attributed to the different lifestyle practices of men and women.

6.2.2 Age

The minimum age of participants were 18 years and the maximum were 60 years of age. Most participants' age ranged from 20-29 years which indicates that the majority of participants who had undergone psychotherapy were youth. The SADAG discovered that of adolescents who commit suicide have an underlying mental illness. Wilson the SADAG founder (Anon. 2019: 1), asserted that *"our teens are depressed and often have no-one to turn to for support".* Almost 25% of adults requesting psychotherapy for depression did not attend an initial visit (Simon and Ludman 2010: 686).

6.2.3 Marital status

Results of the analysis show that the majority of participants were single. These concurs with research findings that consistently found prevalence of depression in unmarried people (Strohschein 2005; Marks and Lambert 1998). Other research studies reveal that marriage is more beneficial for the mental health of men than women (Kiecolt-Glaser and Newton 2001; Wu and DeMaris 1996; Gove and Tudor 1973).

6.2.4 Level of education

According to the current study findings, 50% of participants did not have tertiary qualifications High education plays an important role in mental health (Bjelland *et al.* 2008; Bracke, Pattyn and von dem Knesebeck, 2013). Other studies have also found that less depressive symptoms are present in the more informed group Bjelland *et al.* 2008; Bauldry 2015). Contrary to this, the current study showed that participants had tertiary qualifications, and still had depression. However, in order to have a broad understanding of how the level of education affects patients to present with depression, it is necessary to consider the co-morbiddity factors such as the status of jobs and the social factors.

6.2.5 Occupation

According to Statistics South Africa (2019) 4.1 million citizens were unemployed in 2019. (2019: para. 3 lines 1) Martin Hugo, the founder of the new National Unemployment Support Group (Unemployment Support Group 2019) revealed that finding himself unemployed led to a period of deterioration in his mental health that finally resulted in depression. There is a significant correlation between unemployment and depression. It has been described as a vicious cycle of the relationship between poverty and mental illness. Participants living in poverty are more at risk of developing depression due to the stress of living in poverty, loss of income and unemployment (Patel and Kleinman 2003: 610).

6.2.6 Number of psychotherapy sessions

To participate in the study, participants were required to attend two (2) therapy sessions. After their fourth session majority of the participants ended their therapy. Participants felt comfortable enough to finish treatment, and optimistic enough. Most participants found that termination positively affected them; they felt assured that they should move on with any circumstances in their lives (Hunsley *et al.* 1999: 380; Roe *et al*. 2006: 530).

6.3 DISCUSSION OF THE FINDINGS FROM THE MAIN QUESTION

Participants were asked to share their experience with psychotherapy interactions. Their responses mirrored transactional behavioral shifts from the first session to the third or later sessions of psychotherapy, or the implementation of new interpersonal skills. Participants alluded to previous events or feelings they might have hidden during psychotherapy. Freud, (1917: 1915) argued that repression is a state where you are unaware of having certain troubling motives, but desires still influence you negatively. It is evident that most respondents had certain desires such as employment and financial stability, which may create a conflicted state of mind.

Moreover, long-term psychodynamic therapy is often recommended for patients who experienced difficulties from early childhood and were pervasive. An example of psychodynamic treatment based on object relations in this study was participant (P4), who stated that her challenges originated in childhood. Regarding object relations, theorists stipulated that personal patterns of early childhood caregivers are introjected to individuals (Compton 1996; Kernberg 1976; Greenberg and Mitchell 1983). These patterns countered to act as a template through which other relationships are experienced; relationships are view from the same perspective. Maladaptive patterns were explored in therapy sessions and are understood more fully. Once patients become aware of this behaviour they begin to change.

Participants highlighted that they were able to share their experiences with someone (psychologist) without being judged or misunderstood. Studies indicate that participants were more engaged in therapy when psychologists were caring, supportive and non-judgmental (Levitt *et al.* 2006: 801-830; Timulak *et al.* 2017: 1-12). Participants stated it was easier to open up to a psychologist once they had established a therapeutic alliance (Nilsson *et al.* 2007; Timulak *et al.* 2017: 1-12).

The themes that emerged further explain how depression is best understood from the psychodynamic perspective. The themes that emerged from the analysis of interviews with participants are discussed below.

6.4 DISCUSSION OF THEMES

6.4.1 An understanding of psychotherapy

Participants indicated that disengagement in therapy emanated from a lack of insight and understanding the purpose of psychotherapy prior to the participant's first therapy session. It is significant that patients understand the purpose of psychotherapy prior to their first session to engage in a fruitful

session. Psychologists have a crucial role in explaining the purpose of psychodynamic theory prior the commence of psychotherapy. Psychologists have to elicit that the goals of psychodynamic therapy are client self-awareness and understanding of the influence of the past on present behaviour.

Benefits of psychotherapy sessions

Participants stated that when they received an authentic caring response from the psychologist, it played a critical role in shaping therapeutic alliance. The literature reviewed on patient process-outcome associations have mainly focused on the alliance-outcome relationship. The vast majority of these studies found a positive association between the alliance in one session and symptom change in the next session (Falkenström *et al.* 2013; Hoffart*, et al.* 2013; Zilcha-Mano 2016). Hence, the relationship between the patient and the psychologist is crucial as it facilitates recovery and improved health outcomes.

Several scholars define therapeutic alliance as *"the relationship between a psychologist and a patient, regarded as important for the outcome of psychological therapy as well as agreement about treatment goals and activities"* (Karver *et al.* 2006; Wampold 2015; Cuijpers *et al.* 2008; Norcross 2011). Moreover, Timulak and McElvaney (2013: 131-150) conducted meta-analysis on seven studies that explored participants' experiences of psychotherapy sessions. Findings indicated that psychologists' empathic responding or interpretation of participants' statements appeared to positively support behavioural change. This resulted in more progressive psychotherapy. Meanwhile, participants also asserted that other health care practitioners lack empathy and support.

6.4.2 Challenges with consultation

The participants mentioned that they did not have sufficient time to consult with the practitioners, particularly during the first session. They stated that they needed more time to warm up and become comfortable before they could share some experiences and information they perceived as personal. This is not

surprising as the practitioner is usually a stranger. This situation can be aggravated when the practitioner differs from the patient in terms of age, gender and race. Studies have been conducted on the practice of short-time psychodynamic therapy in correlation with the adjustment of the limited time available for the patient's psychotherapy sessions. Psychologists define short-term, psychodynamic psychotherapy inclusive of the following criteria: the treatment is time-limited, centred and provided to chosen patients; it uses methods that are psychoanalytically inspired, and the philosophy underlying the condition concept is psychoanalytical in the broad sense of the term (Crits-Christoph, Barber and Kurcias: 1991: 1-16). It is important to stress that, for only a certain subset of the patient population, short-term adaptive psychotherapies are sufficient.

Some participants also expressed concerns over booking times. These changed often and some participants could not keep track of these changing times. Consequently, some patients missed consultations because they had forgotten. The staff members responsible for the bookings were not helpful and friendly which made it difficult for the patients to approach them for a rebook. As a result, some of the participants preferred booking their appointments directly with the psychologists in order to avoid the inconvenience of booking through the OPD nurses.

The experiences of the participants also include the problem of shortage of psychologists available to assist patients. In some cases, the psychologists would be booked the whole week and some patients who miss their consultations have difficulty in making another appointment. It has been noted that the ratio of patient to practitioner is highly skewed. The World Health Organisation (WHO) argues that there is a deficiency of human resources (psychiatrists, psychologists, and other mental health professionals), a scarcity of mental health resources (psychiatric beds, diagnostic equipment, essential medicines) and inadequate financial resources, therefore, information on depression is limited (WHO 2005).

6.4.3 Socio-cultural taboos and beliefs

Participants indicated that stigmatizing beliefs on depression reported in South Africa, include beliefs that people with mental illness are bewitched, weak, lazy, mad, insane, not capable of doing anything or unable to think (Evans-Lacko *et al*. 2012: 1741). The implications of such erroneous views are apprehension, mockery and abuse of individuals who are mentally ill. Many individuals have also been neglected, isolated, rejected by family and peers, abused or excluded from social engagement and basic rights. There is a lack of appropriate awareness of psychological health and prevalent stigma against mentally ill people.

Perceived stigma by individuals living with mental illness is reported internationally, although the reasons for stigmatization are not consistent across communities or cultures. For instance, the WMHS showed that stigma was closely associated with anxiety and mood disorders among adults reporting significant disability. The survey data, which included responses from 16 countries in the Americas, Europe, the Middle East, Africa, Asia, and the South Pacific, showed that 22.1% of participants from developing countries and 11.7% of participants from developed countries experienced embarrassment and discrimination due to their mental illness (Alonso *et al.* 2008: 305-314). On the other hand, Abdullah *et al.* (2011: 4-948) who reviewed the study of ethno-cultural values and mental illness discrimination demonstrated the broad range of mental well-being cultural norms, for example, that Indian tribes do not stigmatize mental illness. Although limited studies focused on unhelpful or hindering aspects of psychotherapy, McElvanney and Timulak (2013: 249) found that characteristics such as feeling stigmatized, emotionally overwhelmed and unprotected had potentially impacted the participants' experiences of psychotherapy, negatively.

6.4.4 Therapeutic outcome

Participants acknowledged a change in behaviour and described how psychotherapy equipped them with strategies to have a positive view of life. Psychodynamic therapy was designed to help patients explore the full range of emotions, feelings including unconscious elements to elicit how unresolved issues affect the present life (Crits-Christoph, 1992: 151-158; Messer and Warren, 1995). Psychodynamic therapy attempts to resolve the depression from its aetiology rather than focusing on just changing behaviour (Freud 1917b: 237-258).

Participants highlighted helpful therapeutic outcomes and the development of new interpersonal skills. Studies have shown that a variety of psychotherapy techniques is effective (Beutler 2004; McMain and Pos 2007; Thomas and Zimmer-Gembeck 2007; Shedler 2010). Most participants concluded that they developed certain interpersonal skills after they had attended their fourth psychotherapy session. This concurs with studies on the treatment of depression, which indicated that patients acquired a variety of skills that were used after the termination of therapy. (Hollon, Stewart and Strunk 2006; Shedler 2010)

Furthermore, participants claimed that even though they had terminated psychotherapy, they still use techniques that were taught to them by psychologists. Participants were able to use their discretion to learn from their past experiences and develop strategies to deal with similar stressful circumstances in the future. Several studies measuring psychotherapy effectiveness indicated that patients often benefit from treatment, resulting in continuous improvement of their life thereafter (Abbass *et al.* 2006; De Maat *et al.* 2009; Shedler 2010; Grant *et al.* 2012).

6.5 SUMMARY OF THE CHAPTER

In this chapter, the findings of the study were discussed in relation to the themes and sub-themes that emerged. In the next chapter, the conclusions, limitations, recommendations and areas for future research will be presented.

CHAPTER 7: CONCLUSION, LIMITATIONS AND RECOMMENDATIONS OF THE STUDY

7.1 INTRODUCTION

The aim of the study was to explore and describe the experiences of patients with depression who are receiving psychotherapy in selected public hospitals in eThekwini District. This dissertation explored the background and the importance of the study. Comparison of previous literature reviews indicated a huge gap in the literature exploring the experiences of patients in psychotherapy. The psychodynamic theoretical framework was used to facilitate an understanding of depression. The philosophical views underpinning the study, research design, study setting, population, recruitment, sample process, data collection tool as well as data analysis was discussed in depth in the previous chapters. The conclusions drawn from this study, the limitations of the study as well as the recommendations are based on the findings, will be discussed in this chapter.

7.2 CONCLUSION

South Africa's government hospitals are still faced with the challenge of providing adequate mental health services. The shortage of psychologists within government institutions results in limited consultation times and challenges of booking an appointment. Although the shortage of psychologists may pose challenges in psychotherapy treatment, it is not the only factor that contributes to challenges that affect effective treatment. The cultural stigma also plays a significant role in influencing patients diagnosed with depression not to seek psychotherapy treatment. Nonetheless, participants also discussed positive outcomes of their experiences of psychotherapy. Participants acknowledged that there were behavioral and attitude changes; they changed their perception life; after therapy, they had a positive view life, regardless of

challenges they encounter. Additionally, participants developed new interpersonal skills.

The findings confirmed that the aim of the study was conveyed accurately and participants shared their experiences of psychotherapy. The study was able to address the main research question, that is, *what are the experiences of patients with depression regarding psychotherapy sessions*? Participants' responses elicited more probing questions which were aligned to the research question. The following questions were asked and its responses are discussed below:

a) *What is your understanding of the purpose of psychotherapy?*

The findings of the study showed that it is important for participants to understand the purpose of psychotherapy in order to eliminate any misunderstanding that may arise during psychotherapy. The study further demonstrated that it is important for participants to understand the purpose of psychotherapy and its benefits. Participants that understood the purpose of psychotherapy indicated a positive engagement with the psychologist. In comparison, the participants who lacked an understanding, experienced disengagement with their psychologists. It is, therefore, essential for participants to understand the purpose of psychotherapy prior to commencement of treatment.

b) *What are the challenges or benefits of undergoing psychotherapy for patients with depression*?

The findings indicated that participants experienced difficulties in booking appointments with psychologists. It was also found that there is currently a shortage of psychologists in public hospitals. Participants mentioned that psychotherapy was beneficial for them as there were able to develop new interpersonal skills. Furthermore, they expressed that they were able to confound to psychologists without fear of confidentiality being bridged.

c) *What behavioral or emotional changes patients with depression experience after psychotherapy*?

The findings of the study indicated that participants experienced behavioral changes. Participants were able to adopt a positive mindset towards challenges they may encounter. Respondents also indicated that they developed new interpersonal skills.

7.3 LIMITATIONS

Limitations are the weaknesses of a study (Rossman and Rallis 2016: 119). Caution of such limitations in the study consents individuals to take into consideration for a fair evaluation of findings (Rossman and Rallis 2016: 119). The study was conducted with a small number of participants. Generalization of the study findings to the larger population may be inappropriate because the sample did not represent the experiences of all patients who had received psychotherapy, although, these participants were able to produce rich qualitative data.

Another limitation was that the researcher was not able to verify the patients' comorbidity, such as Schizophrenia, because she was not granted permission to view patients' medical records. Certain participants refused to be recorded during the interviews, this set a limitation. The analysis of patients' perspectives, may under certain circumstances, result in unreliable sources of information. Clients may not be conscious of or may not remember particular aspects or events in therapy. They will, sometimes, deliberately or unconsciously limit or distort information given to the researcher (Rennie 1986: 896). The reports are considered biased on the premise that responses are pre-set and based on existing beliefs and ideas patients may already have. External factors, lack of vocabulary, or idiosyncratic interpretation of items can reduce reliability.

7.4 RECOMMENDATIONS

Based on the findings of the study, the following recommendations are made with special reference to integration of mental health into PHC:

- organizing campaigns on the purpose and importance of psychotherapy treatment;
- addressing shortage of resources;
- breaking barriers to adopt effective and efficient psychotherapy.
- There is a high prevalence of an uneven ratio of psychologists to patients needing psychotherapy treatment in government hospitals. Therefore, a suitable funding model should be established and more posts can be created within the mental health field.
- Cultural barriers, including the stigma associated with seeking mental health services, also reduces the likelihood of people receiving psychotherapy they need.
- There is a need for establishing a coordinating body to oversee public education and awareness campaigns on mental health and mental disorders in South Africa to create awareness of the need for people to seek psychotherapy, as well as to reduce the stigma surrounding psychotherapy and depression.
- Currently, patients are unable to book appointments directly with the psychologists. A referral letter is required from a medical doctor which is inconvenient as, quite often, patients require assistance as a matter of urgency. This acts as a barrier to efficient psychotherapy for patients in an emergency.
- Developing a framework that will permit patients to have access to psychologists at an ease, will play a major role in addressing the high level of suicidal attempts citizen struggle with daily. Nonetheless in

constructing this framework it should ensure protection of the psychologists as they are already over burden with workload. Typically, perhaps one psychologist can be designated for this emergency appointments.

- Participants revealed that other health care workers often ill-treated them during their hospitalisation after failed suicidal attempts. Therefore, it is imperative for other health care workers to be adequately knowledgeable about depression and appropriate therapeutic approached. Health care workers should be educated on mental health to avoid deterioration of patients after their psychotherapy sessions.

- A strategy to enhance collaboration between health workers, such as nurses and doctors, and psychologists should be formulated to provide better care for patients with depression.

7.4 FURTHER RESEARCH

Researchers should investigate effectiveness of group therapy in public hospitals. Even though the government may increase the number of psychologists in public hospitals, it will still take a long time to balance the ratio between the available psychologists and patients. Therefore, future research into the effectiveness of group therapy in public hospitals is crucial. Investigating the feasibility of group therapy will indicate probabilities in the decrease of numbers of patients receiving psychotherapy; of the targeted population (depressed patients).

7.6 FINAL CONCLUSION

The study explored patients' experiences on psychotherapy sessions. Seventeen participants were interviewed in public hospitals based in eThekwini. The findings presented slight challenges: patients experienced a

challenge with negotiating booking times and consultation times seemed insufficient for patients especially during their first sessions. Stigma, as well as cultural influences were considerable challenges that influenced patients not to seek psychotherapy early. The study findings can be employed for several functions: firstly, it will better enlighten health practitioners on patients' experiences, this as background information to better advance psychotherapy. Secondly establishment of new policies that will promote an increase in and easy access to psychotherapy sessions in government hospitals. Thirdly, the Department of Health can use the study findings as a basis to increase its efforts to educate the public about the effectiveness of psychotherapy and support advocacy eff orts to enhance formal recognition of psychotherapy in the mental health system.

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APPENDICES

Appendix 1: DUT Ethics clearance

Institutional Research Ethics Committee
Research and Postgraduate Support Directorate
2nd Floor, Berwyn Court
Gate 1, Steve Biko Campus
Durban University of Technology

P.O Box 1334, Durban, South Africa, 4001

Tel: 031 373 2375
Email: lividsd@dut.ac.za
http://www.dut.ac.za/research/institutional_research_ethics

www.dut.ac.za

16 July 2019

Ms N P Ndokweni
P.O Box 2364
Pinetown
3600

Dear Ms Ndokweni

Experiences of patients with depression who are receiving psychotherapy in selected public hospitals in eThekwini District, KwaZulu-Natal.
Ethical Clearance number IREC 099/19

The Institutional Research Ethics Committee acknowledges receipt of your gatekeeper permission letter.

Please note that FULL APPROVAL is granted to your research proposal. You may proceed with data collection.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC Standard Operating Procedures (SOP's).

Please note that any deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

Yours Sincerely

Professor J K Adam
Chairperson: IREC

Appendix 2a: Letter of permission to the District Manager of eThekwini Health District

19433 Mthiya Rd.
Mbhedula, Klaarwater
Pinetown
3609
[Date]

The District Manager
EThekwini Health District
P/Bag X54318
Durban
4000

Request for Permission to Conduct Research

Dear Dr Green

My name is Ms Ntokozo Ndokweni, a Master of Health Sciences student at the Durban University of Technology. My research topic is: *Experiences of patients with depression who are receiving psychotherapy in selected public hospitals in eThekwini District, KwaZulu-Natal*.

I am hereby seeking your consent to interview patients for the study. In order to conduct this study, your permission is requested to conduct individual interviews on patients diagnosed with depression and who are currently on psychotherapy at King Dinuzulu, King Edward and R.K. Khan Hospitals.

I have provided you with a copy of my proposal which includes copies of the data collection tools and consent and/ or assent forms to be used in the research process, as well as a copy of the approval letter which I received from the Institutional Research Ethics Committee (IREC).

If you require any further information, please do not hesitate to contact my supervisor, Prof M.N. Sibiya, email: nokuthulas@dut.ac.za

Thank you for your time and consideration in this matter.

Yours sincerely,

_____

Ms N. Ndokweni
Durban University of Technology
Email: NtokozoN2@dut.ac.za
Cell: 079 010 1220

Appendix 2b: Approval letter from the District Manager of eThekwini Health District

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE: CORPORATE SERVICES

83 King Cetshwayo Highway
Mayville, Durban, 4001
Tel: 031 240 5455 Email:
www.kznhealth.gov.za

ETHEKWINI HEALTH DISTRICT OFFICE

27th June 2019

Dear Ms Ntokozo Ndokweni
Re: Permission To Conduct Research at eThekwini District Facilities.

This letter serves to confirm that your application to conduct the research study titled, "**Experiences of patients with depression who are receiving psychotherapy in selected public hospitals in eThekwini District, KwaZulu-Natal.**" in the eThekwini district at the following health care facilities has been recommended:

1. King Dinuzulu,
2. King Edward and
3. R.K. Khan Hospitals

Kindly upload this letter together with your application as required to the Health Research and Knowledge Unit for the KZN Department of Health for Approval.

Please also note the following:

1. This research project should only commence after final approval by the KwaZulu-Natal Health Research and Knowledge Unit, and full ethical approval, has been granted,
2. That you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
3. All research activities must be conducted in a manner that does not interrupt clinical care at the health care facility,
4. Ensure that this office is informed before you commence your research
5. The District Office/Facility will not provide any resources for this research
6. All logistical details must be arranged with the CEO/medical manager /operational manager of the facility,
7. You will be expected to provide feedback on your findings to the District Office/Facility

Yours sincerely

_____
Dr N Green(District Research Coordinator)
Pp Ms. T. P. Msimango
Chief Director (Acting)
eThekwini Health District

Appendix 3a: Letter of permission to the KZN Department of Health

19433 Mthiya Rd.
Mbhedula, Klaarwater
Pinetown
3609
[Date]

The Health Research and Knowledge Management Component
KwaZulu-Natal Department of Health
Private Bag X9051
Pietermaritzburg
3201

Request for Permission to Conduct Research

Dear Dr Lutge

My name is Ms Ntokozo Ndokweni, a Master of Health Sciences student at the Durban University of Technology. My research topic is: *Experiences of patients with depression who are receiving psychotherapy in selected public hospitals in eThekwini District, KwaZulu-Natal*.

I am hereby seeking your consent to interview patients for the study. In order to conduct this study, your permission is requested to conduct individual interviews on patients diagnosed with depression and who are currently on psychotherapy at King Dinuzulu, King Edward and R.K. Khan Hospitals.

I have provided you with a copy of my proposal which includes copies of the data collection tools and consent and/ or assent forms to be used in the research process, as well as a copy of the approval letter which I received from the Institutional Research Ethics Committee (IREC).

If you require any further information, please do not hesitate to contact my supervisor, Prof M.N. Sibiya, email: nokuthulas@dut.ac.za

Thank you for your time and consideration in this matter.

Yours sincerely,

_____

Ms N. Ndokweni
Durban University of Technology
Email: NtokozoN2@dut.ac.za
Cell: 079 010 1220

Appendix 3b: Approval letter from the KZN Department of Health

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: 330 Langalibalele Street, Pietermaritburg
Postal Address: Private Bag X9051
Tel: 033 395 2805/ 3189/ 3123 Fax: 033 394 3782
Email:
www.kznhealth.gov.za

DIRECTORATE:
Health Research & Knowledge Management

NHRD Ref: KZ_201906_042

Dear Ms NP Ndokweni
DUT

Approval of research

1. The research proposal titled **'Experiences of patients with depression who are receiving psychotherapy in selected public hospitals in eThekwini District, KZN'** was reviewed by the KwaZulu-Natal Department of Health.

   The proposal is hereby **approved** for research to be undertaken at King Dinuzulu Hospital Complex, RK Khan and King Edward VIII Hospital.

2. You are requested to take note of the following:
   a. Kindly liaise with the facility manager BEFORE your research begins in order to ensure that conditions in the facility are conducive to the conduct of your research. These include, but are not limited to, an assurance that the numbers of patients attending the facility are sufficient to support your sample size requirements, and that the space and physical infrastructure of the facility can accommodate the research team and any additional equipment required for the research.
   b. Please ensure that you provide your letter of ethics re-certification to this unit, when the current approval expires.
   c. Provide an interim progress report and final report (electronic and hard copies) when your research is complete to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

Dr E Lutge
Chairperson, Health Research Committee
Date: 05/07/19

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 4a: Letter of permission to the Hospital Manager: RK Khan Hospital

19433 Mthiya Rd.
Mbhedula, Klaarwater
Pinetown
3609
[Date]

The Hospital Manager
RK Khan Hospital
336 R K Khan Cir, Arena Park
Chatsworth
4092

Request for Permission to Conduct Research

Dear Sir/Madam

My name is Ms Ntokozo Ndokweni, a Master of Health Sciences student at the Durban University of Technology. My research topic is: *Experiences of patients with depression who are receiving psychotherapy in selected public hospitals in eThekwini District, KwaZulu-Natal*.

I am hereby seeking your consent to interview patients for the study. In order to conduct this study, your permission is requested to conduct individual interviews on patients diagnosed with depression and who are currently on psychotherapy at your facility.

I have provided you with a copy of my proposal which includes copies of the data collection tools and consent and/ or assent forms to be used in the research process, as well as a copy of the approval letter which I received from the Institutional Research Ethics Committee (IREC).

If you require any further information, please do not hesitate to contact my supervisor, Prof M.N. Sibiya, email: nokuthulas@dut.ac.za

Thank you for your time and consideration in this matter.

Yours sincerely,

_____

Ms N. Ndokweni
Durban University of Technology
Email: Email: NtokozoN2@dut.ac.za
Cell: 079 010 1220

Appendix 4b: Approval letter from the Hospital Manager: RK Khan Hospital

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address : R.K. Khan Circle
Physical Address : CHATSWORTH
Tel: [031] 4596001 Fax:[031] 4011247 Email:Sharon.gounden@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:
R.K. KHAN HOSPITAL
OFFICE OF THE CEO

ENQUIRIES : DR P.S. SUBBAN

27 JUNE 2019

Ms N.P. Ndokweni
P.O. Box 2364
PINETOWN
3600

Dear Ms Ndokweni

RE: PERMISSION TO CONDUCT RESEARCH: EXPERIENCE OF PATIENTS WITH DEPRESSION WHO ARE RECEIVING PSYCHOTHERAPY IN SELECTED PUBLIC HOSPITALS IN ETHEKWINI DISTRICT, KWAZULU-NATAL

Permission is granted to conduct the study at this institution.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures protocols and guidelines of the Institution with regards to this research.

2. Please ensure this office is informed before you commence your research and your University's Ethics approval must be attached.

3. You will be expected to provide feedback on your findings to this institution.

4. You will be liaising with: Dr Y. Asmal
Head of Department - Psychiatry
Tel: [031 – 4596406]

Yours faithfully

DR P.S. SUBBAN
CHIEF EXECUTIVE OFFICER

Appendix 5a: Letter of permission to the Hospital Manager: King Edward VIII Hospital

19433 Mthiya Rd.
Mbhedula, Klaarwater
Pinetown
3609
[Date]

The Hospital Manager
King Edward Hospital VIII
Sydney Rd, Umbilo
Durban
4013

Request for Permission to Conduct Research

Dear Sir/Madam

My name is Ms Ntokozo Ndokweni, a Master of Health Sciences student at the Durban University of Technology. My research topic is: *Experiences of patients with depression who are receiving psychotherapy in selected public hospitals in eThekwini District, KwaZulu-Natal*.

I am hereby seeking your consent to interview patients for the study. In order to conduct this study, your permission is requested to conduct individual interviews on patients diagnosed with depression and who are currently on psychotherapy at your facility.

I have provided you with a copy of my proposal which includes copies of the data collection tools and consent and/ or assent forms to be used in the research process, as well as a copy of the approval letter which I received from the Institutional Research Ethics Committee (IREC).

If you require any further information, please do not hesitate to contact my supervisor, Prof M.N. Sibiya, email: nokuthulas@dut.ac.za

Thank you for your time and consideration in this matter.

Yours sincerely,

_____

Ms N. Ndokweni
Durban University of Technology
Email: NtokozoN2@dut.ac.za
Cell: 079 010 1220

Appendix 5b: Approval letter from the Hospital Manager: King Edward VIII Hospital

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

OFFICE OF THE HOSPITAL CEO
KING EDWARD VIII HOSPITAL

Private Bag X02, CONGELLA, 4013
Corner of Rick Turner (Francois Road) & Sydney Road
Tel: 031-3603853, Fax:031-2061457; Email: [redacted]
www.kznhealth.gov.za

Ref.: KE 2/7/1/ (29/2019
Enq.: Mrs. R. Sibiya
Research Programming

09 July 2019

Ms N. Ndokweni
DUT University of Technology

Dear Ms Ndokweni

Protocol: "Experience of patients with depression who are receiving psychotherapy in selected public hospitals in eThekwini District, KwaZulu-Ntala"

Permission to conduct research at King Edward VIII Hospital is provisionally granted, pending approval by the Provincial Health Research Committee, KZN Department of Health.

Kindly note the following:-

- The research will only commence once confirmation from the Provincial Health Research Committee in the KZN Department of Health has been received.
- Signing of an indemnity form at Room 8, CEO Complex before commencement with your study.
- King Edward VIII Hospital received full acknowledgment in the study on all Publications and reports and also kindly present a copy of the publication or report on completion.

The Management of King Edward VIII Hospital reserves the right to terminate the permission for the study should circumstances so dictate.

Yours faithfully

SUPPORTED/NOT SUPPORTED

12/07/2019

DR. S. RAMJI
ACTING MEDICAL MANAGER

DATE

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 6a: Letter of permission to the Hospital Manager: King Dinuzulu Hospital

19433 Mthiya Rd.
Mbhedula, Klaarwater
Pinetown
3609
[Date]

The Hospital Manager
King Dinuzulu Hospital
Corner of Dr. Naidu Drive & Viola Rd.
Sydenham
Durban
4091

Request for Permission to Conduct Research

Dear Sir/Madam

My name is Ms Ntokozo Ndokweni, a Master of Health Sciences student at the Durban University of Technology. My research topic is: *Experiences of patients with depression who are receiving psychotherapy in selected public hospitals in eThekwini District, KwaZulu-Natal*.

I am hereby seeking your consent to interview patients for the study. In order to conduct this study, your permission is requested to conduct individual interviews on patients diagnosed with depression and who are currently on psychotherapy at your facility.

I have provided you with a copy of my proposal which includes copies of the data collection tools and consent and/ or assent forms to be used in the research process, as well as a copy of the approval letter which I received from the Institutional Research Ethics Committee (IREC).

If you require any further information, please do not hesitate to contact my supervisor, Prof M.N. Sibiya, email: nokuthulas@dut.ac.za

Thank you for your time and consideration in this matter.

Yours sincerely,

_____

Ms N. Ndokweni
Durban University of Technology
Email: Email: NtokozoN2@dut.ac.za
Cell: 079 010 1220

Appendix 6b: Approval letter from the Hospital Manager: King Dinuzulu Hospital

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address :75 R.D. Naidu road, Sydenham
Physical Address:PO Domerton ,4015
Tel: 031 242 6000 Fax: 031 2099586
Email address:shanil: .maharaj@kznhealth.gov. za
www.kznhealth.gov.za

DIRECTORATE:
King Dinuzulu Hospital Complex

Enquiries: Dr S.B. Maharaj
Date: 16/08/2019

Dear Ms N. Ndokweni

RE: PERMISSION TO CONDUCT RESEARCH AT KING DINUZULU HOSPITAL COMPLEX- "Expperiences of patients with depression who are receiving psychotherapy in selected public hospitals in Ethekwini District, kwaZulu-Natal"

I have pleasure in informing you that permission has been granted to you by King Dinuzulu Hospital Complex to conduct your Research, provided we can also see the poster before it is put up.

Please note the following:

1. Please ensure that you adhere to all policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure that this office is informed before you commence your research.
4. Neither the District Office nor KDHC will provide any resources for this research.
5. Your attention is drawn to the maintenance of confidentiality with respect to patient's records/files.
6. You will be expected to provide feedback on your findings to KDHC.

Yours sincerely

DR S.B. MAHARAJ
MEDICAL MANAGER

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 7a: Letter of information for interview participants (English)

Dear Participant

Thank you for agreeing to participate in the study.

Title of the Research Study: Experiences of patients with depression who are receiving psychotherapy in selected public hospitals in eThekwini District, KwaZulu-Natal.

Principal Investigator/s/researcher: Ms Ntokozo Ndokweni, MHSc Candidate.

Co-Investigator/s/supervisor/s: Prof M.N. Sibiya, D Tech: Nursing (Supervisor); Dr P.B. Nkosi, PhD Health Sciences (Co-supervisor).

Brief Introduction and Purpose of the Study: This research aims to explore and understand the experiences of undergoing psychotherapy treatment for patients with depression. There is a lack of South Africa context orientated approach to psychotherapy treatment that derived from the patients with depression perspectives to problematic life issues. The question on the influence of psychotherapy orientation on treatment effectiveness have been longstanding and debated.

Outline of the Procedures: You are kindly requested to participate in the interview, which will last for about 30-45 minutes. The interview will consist of eight questions excluding the demographics questions, additionally more questions may be asked during the interview as some will be a result of probing from the participant's responses. I kindly request to use the voice recorder to capture the entire conservation dialogue. The use of voice recorder will be used to minimize the use of note-taking as that could interfere with ongoing eye contact.

Risks or Discomforts to the Participant: Minimal risks may occur such as emotional distress.

Benefits: The findings of the study will add to body of knowledge of psychotherapy and thus provide an enlightenment for future innovate strategies for therapists.

Reason/s why the Participant May Be Withdrawn from the Study: You can withdraw from the study at any given time without any form of penalty.

Remuneration: There is no remuneration for participating in the study.

Costs of the Study: There are no costs involved by participating in this study.

Confidentiality: The information provided will be kept strictly confidential and will remain anonymous. Your name will not be documented in the research documents; instead codes will be used.

Research-related Injury: There are no foreseen risks and discomforts related to you in this study, nevertheless, if so, no compensation will be presented.

Persons to Contact in the Event of Any Problems or Queries: Please contact the researcher Ms Ntokozo Ndokweni tel no.: 031-373 2706, my supervisor Prof. M.N. Sibiya tel no.: 031-373 2704 or the Institutional Research Ethics Administrator on 031-373 2375. Complaints can be reported to the DVC: Research, Innovation and Engagement, Prof S. Moyo on 031-373 2577 or moyos@dut.ac.za

Appendix 7b: Incwadi yolwazi (IsiZulu)

Mhlanganyeli Othandekayo

Siyabonga ngokuvuma ukubamba iqhaza ocwaningweni.

Isihloko Socwaningo: Izingqinamba ezihlangabezana neziguli ezinenkinga yokucindezeleka komqondo ezithola ukwelashwa nge-psychotherapy esifundeni saseThekwini, KwaZulu-Natali.

Umncwaningi / umcwaningi oyinhloko: uNksz Ntokozo Ndokweni, Umfundi weziqu zeMastazi.

Umcwaningi owelekelelayo / Umholi: USolwazi M.N. Sibiya, Uneziqu zobudokotela emkhakheni wabahlengikazi (Umhloli); Dkt. P.B. Nkosi, Uneziqu zobudokotela emkhakheni wezempilo (Umlekeleli womhloli).

Isingeniso esifushane kanye nenhloso yocwaningo: Lolu cwaningo luhlose ukuhlola nokuqonda izingqinamba ezihlangabezana neziguli ezithola ukwelashwa ezinokucindezeleka kwengqondo. Kukhona ukwesweleka kwezindlela zokwelashwa ezincike ezindleleni zaseSouth Africa nezisungulwe ngokubheka izingqinamba iziguli ezibhekana nazo ekwelasheni nge psychotherapy. Umbuzo ngemithelela ye-psychotherapy ekwelashweni isibe sematheni nasezimpikiswaneni isikhathi eside.

Uhlaka Lwezinqubo: Uyacelwa ukuba uhlanganyele engxoxweni ezohlala cishe imizuzu engama-30-45. Le ngxoxo izoba nemibuzo eyisishiyagalolunye ngaphandle kwemibuzo mayelana nemibandela yabantu, imibuzo engaphezulu ingase ibuzwe ngenkathi kuxoxwa ngayo njengoba abanye bazoba yingxenye yokucubungula impendulo yomhlanganyeli. Ngiyacela ngomusa ukusebenzisa isiqopha mazwi ukuthatha inkulumompendulwano yonke ngenhloso yokuyigcina. Ukusetshenziswa kwesiqophamazwi kuzosetshenziselwa ukunciphisa ukusetshenziswa kokubhala amanothi ngoba lokho kungaphazamisa ukuxhumana kwamehlo okuqhubekayo.

Izingozi noma ukuphazamiseka kumuntu ohlanganyele: Izingozi ezincane zingase zibe khona, njengokucindezeleka ngokwemizwa.

Inzuzo: Okutholakele kulolu cwaningo kuyokwengeza emzimbeni wolwazi lwe-

psychotherapy futhi ngaleyo ndlela kuzoletha ulwazi namasu ukulekelela abahlengikazi esikhathini esizayo.

Isizathu / Kungani Umhlanganyeli Angahle Ahoxiswe Esifundweni: Ungakwazi ukuhoxisa esifundweni nganoma isiphi isikhathi ngaphandle kwendlela yokujeziswa.

Umholo: Akukho mholo wokubamba iqhaza kulolu cwaningo.

Izindleko zocwaningo: Azikho izindleko ezihambisana nokuhlanganyela kulolu cwaningo.

Okuyimfihlo: Ulwazi olunikeziwe luzogcinwa luyimfihlo futhi luzohlala lungaziwa. Igama lakho ngeke libhaliswe emaphepheni ocwaningo; esikhundleni kuzosetshenziswa amakhodi.

Ukulimala okuhlobene nocwaningo: Azikho izingozi
ezingabonakali nokungahambi kahle okuhlobene nawe kulolu cwaningo, noma kunjalo, uma kunjalo, akukho sinxephezelo esizokwethula.

Abantu abazoxhumana nabo emcimbini wezinkinga noma imibuzo: Sicela uxhumane nomcwaningi uNksz Ntokozo Ndokweni tel no.: 031-373 2706, umphathi wami uSolwazi. M.N. Sibiya inombolo yocingo: 031-373 2704 noma uMqondisi wezokuHlaliswa koHlelo lwe-Institutional, ngo-031-373 2375. Izikhalazo zingabikwa kuMqondisi: Wezocwaningo, uSolwazi S. Moyo ngo-031-373 2577 noma moyos@dut.ac.za

Appendix 8a: Consent

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Ms N.P. Ndokweni about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: _____,
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

_____	_____	_____	_____
Full Name of Participant	**Date**	**Time**	**Signature / Right Thumbprint**

I, Ntokozo Pearl Ndokweni herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

_____	_____	_____
Full Name of Researcher	**Date**	**Signature**
_____	_____	_____
Full Name of Witness (If applicable)	**Date**	**Signature**
_____	_____	_____
Full Name of Legal Guardian (If applicable)	**Date**	**Signature**

Appendix 8b: Imvume (isiZulu)

Isitatemende sesivumelwane sokubamba iqhaza esifundweni sokucwaninga:

☐ Ngifakazela ukuthi umcwaningi, Nksz Ntokozo Ndokweni, ungichazelile mayelana nemvelo, ukuziphatha, izinzuzo kanye nezingozi zalolu cwaningo- Inombolo Yemvume Yokuhlanganyela:_____,

☐ Ngiphinde ngathola, ngafunda futhi ngaqonda imininingwane ebhalwe ngenhla (kwincwadi yocwaningo) mayelana nocwaningo.

☐ Ngiyazi ukuthi imiphumela yocwaningo, kufaka phakathi imininingwane yomuntu mayelana nobulili bami, ubudala, usuku lokuzalwa, ukuqala kanye nokuxilongwa kuzokhishwa ngendlela eyimfihlo kulombikongombiko walolu cwaningo.

☐ Ngenxa yezidingo zocwaningo, ngiyavuma ukuthi imininingwane eqoqwe phakathi nalolu cwaningo ingacubungulwa ohlelweni lwekhompyutha ngumcwaningi.

☐ Ngingakwazi, nganoma yisiphi isigaba, nangaphandle kokubhekana nezingqinamba ukuthi, ngihoxise imvume yami yokuhlanganyela kulolu cwaningo.

☐ Nginethuba elanele lokubuza imibuzo futhi (ngokuzithandela kwami) ngizibophezele ukuthi ngilungele ukuhlanganyela kulolu cwaningo.

☐ Ngiyoqonda ukuthi ukutholakala kolwazi olusha oluphawulekayo olutholakale phakathi nalolu cwaningo, okungenzeka kube oluphathelene nokuhlanganyela kwami luzovezwa kimi.

_____	_____	_____	_____
Igama eliphelele lomhla Wokubamba iqhaza I- Thumbprint	**Usuku**	**Isikhathi**	**Isingesha/ kwesokudla**

Mina, _____(igama lomcwaningi) lapha ukuqinisekisa ukuthi umhlanganyeli ngenhla wazisiwe ngokugcwele ngesimo, ukuziphatha nezingozi zesifundo esingenhla.

_____	_____	_____
Igama eliphelele lomcwaningi	**Usuku**	**Isignesha**
_____	_____	_____
Igama eliphelele loFakazi (uma likhona)		**Usuku** **Isignesha**
_____	_____	_____
Igama eliphelele le-Legal Guardain	**Usuku**	**Isignesha**

Appendix 9a: Demographic data for the interview participants (English)

Participant Code:

Date of interview: ……..

SECTION A: DEMOGRAPHIC DATA

1. Age: ……..
2. Gender:……
3. Marital Status: ……
4. Level of education: ……
5. Occupation ……
6. Number of psychotherapy sessions……

Appendix 9b: Interview guide questions

Grand tour question

- What are the experiences of patients with depression regarding psychotherapy sessions?

Interview questions

- In your understanding, what is the purpose of psychotherapy?
- Were there any challenges you experienced during psychotherapy sessions?
- Would you say psychotherapy is beneficial? If yes, in what way?
- What are your views on psychotherapy being administered in your non-native language?
- How do you feel after psychotherapy sessions, would you say it the same feelings you experienced before the sessions?
- What gestures would you make for therapists with regards to techniques they use in therapy sessions?

Appendix 10a: Imininingwane yababambiqhaza kucwaningo (IsiZulu)

Ikhodi yemininingwane: 

Usuku lokuxoxa: ……..

<u>Isigaba A: Imininingwane</u>

1. Iminyanka: ……..
2. Ubulili: …….
3. Isimo somshado: ……
4. Izinga lemfundo: ……
5. Umsebenzi owenzayo …….
6. Isikhathi se-psychotherapy (Inombolo yeminyaka / izinyanga) .....

Appendix 10b: Umhlahlandlela wokuxoxa

Umbuzo omkhulu

- Ithini imizwa yakho mayelana nokululekwa ngokomqondo, phecelezi *psychotherapy*?

Imibuzo yokuthasisela

- Ngolwazi lwakho, iyini injongo ye-*psychotherapy*?
- Yiziphi izinselelo ozibonile ngesikhathi se-*psychotherapy*?
- Ngaziphi izindlela ongasho ukuthi ama-*psychotherapy* sessions abe ukwelashwa okuyimpumelelo kweziguli ezicindezelekile?
- Yimiphi imibono yakho nge-psychotherapy ephathwa ngolimi lwakho olungelona uqobo?
- Uzizwa kanjani emva kwe-seshini yakho ye-*psychotherapy*, ungabe uzizwa ngendlela efanayo njengangaphambi kwamaseshini?
- Yisiphi isenzo ongayenza noma uzisho kubelapha ngokuqondene namasu abawasebenzisa ekusebenziseni ukwelapha?

Appendix 11a: Sample of a transcript (English)

Date: 28/08/19

Introduction

Before we start can you kindly grant us permission to utilize a voice recorder, the reason is to ensure we leave nothing out when we transcribe. No recording will be accessed by external members beside me. It is strictly confidential.

Introduction

Hello my name is Ntokozo Ndokweni, the researcher. What we currently have in front of us is a letter of information and a consent form. Its' simply state and explains that all we'll be discussing is strictly confidential, no third person will be involved. The anticipated duration for interview will be not more than 45minuteis (Please turn over).

The next page is the consent form that you can sign if you understood the information provided in the information letter. It's serve as an indicator that you have granted us permission to conduct this interview and you are aware of the tape recordings. If you agree with all that has been mention please kindly sign here (points out space provided) for me. The purpose of the research is to explore and understand the experiences of undergoing psychotherapy treatment for patients with depression.

Interviewer: What are your experiences regarding psychotherapy sessions?

Participant: They were helpful because they gave positive energy and outlook to life because like everything was just negative at that time and they just gave advice on how to handle life, and help me get through depression.

Interviewer: So you were able to change how you view life, you now have a positive outlook?

Participant: Yes, but it doesn't happen immediately because like after being in hospital I did try to kill myself a couple of times but after attending couple few sessions every month I was ok.

Interviewer: At first, how was your first session like?

Participant: It was ok but I didn't understand why that lady had so many questions, but later on I understand she was just trying to understand what type of a person I was and what was I going through. I was resistance and was in a hurry to go home but now I understand better.

Interviewer: What were the challenges you experienced during psychotherapy?

Participant: I don't think there were challenges at that time, I would say understanding the purpose of going to see a therapist. During the time when I was hospitalized the nurses were not as understanding and patient with us. Nurses were judgmental, they give you that look and ill treatment because you tried to take you own life. They saw us as failures and they fail to understand where we come from and our experiences, they portray us as failures. If they were working more like psychologists perhaps patients would be less depressed. Even the nurses add more stress because they have patients for the longest time in the ward. So if they can be more understanding and caring.

Interviewer: Do you understand that the level of training between a psychologist and a nurse with regards to mental illness are not the same? So would you than make a recommendation the other staff members at least receive primary education on depression or mental illnesses perhaps a short course and have more campaigns?

Participant: And they should understand that everyone is different and we deal with things differently. They should stop giving us that look like we have failed in life causes us more stress.

Interviewer: At the time of seeing the therapist you were hospitalized?
Participant: Yes, but I had to attend sessions every month after being discharged, I went few times than I stopped because I was feeling much better.

Interviewer: You stopped?
Participant: I ended-up not going to my following session because I didn't see the need no more, I was stronger and understood everything that was going on with my life.

Interviewer: So you can say psychotherapy was beneficial for you?
Participant: Yes, it was. After I attended psychotherapy I was a complete new person, I have learned to love myself more and accept things as there were. In 2017, I suffered depression again but because of the sessions I attended I was able to try contain myself from and not do anything stupid, always look at the bright side like eventually it will pass and everything will be ok. So, like every time I have an episode life it just not going well I always just try to remember the things they said like 'it won't last forever and life is more important'. They had given me skill to deal with things even-thou it happened lot time ago I can still use it now because depression is not something you have it now and you will never have it again, it's triggered by something

Interviewer: Did you have trouble with the therapy being conducted in English?
Participant: No I understood well

Interviewer: Is there anything else you would like to add?
Participant: No, beside if everyone could just be patient with everyone it could help a lot.

Interviewer: Thanks so much for your time. Should you wish to add something feel free to contact me.

Appendix 11b: Sample of a transcript (IsiZulu)

Ngaphambi kokuthi siqale, ngicela ungipha imvumo yokuebenzisa isiqophamazwi. Isizathu salokhu ukuthi siqinisekise ukuthi asishiyi lutho ngaphandle uma sesishicilela. Okuqoshwa lapha ngeke kunikezwe muntu ngaphandle kokusetshenziswa umcwaningi, kuyimfihlo.

Isingeniso

Sawubona, igama lami ngingu Ntokozo Ndokweni, umcwaningi. Lokhu okuphambi kwethu yincwadi yemininingwane kanye nefomu lemvume. Lezi zinto ziveza ziphinde zichaze ukuthi konke esizokuxoxa kuyimfihlo, akekho umuntu ozongenelela kukho. Lengxoxo izothatha isikhathi esingevile kwimzuzu engu 45 (ngicela uphendule ikhasi).

Ikhasi elilandelayo yifomu lemvumo ongalisayinda uma uma uqonda imininingwane enikezelwe encwadini yemininingwane. Iveza ukuthi usinikezile imvumo yokwenza lenkulumo nokuthi wazisiwe ngokuqoshwa kwayo. Uma uvumelana nakho konke osekukhulunyiwe ngicela usayinde lapha (ekhomba indawo ebekwelwe ukusayinda). Inhloso yalolucwaningo ukubheka nokuqonda izinqinamba zokulashwa nge *psychotherapy* ezigulini ezinokucindezeleka.

Umcwaningi: Ufisa lenkulumo siyiqhube ngesiZulu?
Umbambiqhaza: Ngicela sisebenzise isiZulu.
Umcwaningi: Kulungile, sizosebenzisa isiZulu ulimi lwasekhaya, ulimi lwebele.

Umcwaningi: Ngolwazi lakho iyini injongo yepsychotherapy?
Umbambiqhaza: Ngingathi ngamaphuso nje yilapho khona abantu bakwazi khona ukwelulekwa ngokoqondo futhi bakwazi ukuthulula isifuba sabo.

Umcwaningi: Yiziphi izingqinamba maqondana namaseshini epsychotherapy?
Umbambiqhaza: Ngingathi ibe wusizo ngoba kwakukhona umuntu engingaxoxa naye ngezinkinga zami futhi wangilalela, uyabona leyonto. Kwakukhona umuntu olalele izinkinga zami. Walalela ukuthi ngizizwa kanjani nokuthi ubuhlungu engangikubo ngibuzwa kanjani. Ngakwazi ukumelana nezinto, uyabona leyonto? Yize ezibhedlela zikahulumeni kunokujikeleza. Kodwa kwaba usizo.

Umcwaningi: Ngemumva kweseshini yokuqala wazizwa kanjani?
Umbambiqhaza: Ngazizwa ngikhululekile, noma yini athi angiyenze kumele ngiyenze ukuze abone ukuthi kwaba khona inqubekela phambili. Kanti nami ngibone inqubekela phambili.

Umcwaningi: Uthe kuyajikeleza ezibhedlela zikahulumeni, kanjani, ngicela uchaze?
Umbambiqhaza: Kwaba nezingqinamba ngoba kwezinye izikhathi angikwazanga ukuya ngenxa yesikhathi, mhlawumbe uthole ukuthi ngesikhathi engifika ngaso ebesibekiwe asigcineki noma sengilibalekile. Uthole ukuthi angizombona udokotela ngenxa yokugcwala.

Umcwaningi: Wawunikezwa usuku lokubuya uma ugcine ungambonanga udokotela?
Umbambiqhaza: Yebo, kodwa kwakusho okunye ukubambezeleka. Ezibhedlela zikahulumeni loluhlobo lodokotela luyashoda, ngisho ama psychologists. Yabo njengoba kuwu June manje, uma ngeqiwe yiphoyinti kule nyanga ngingakwazi ukuthola isikhala ezinyangeni ezimbalwa ezizayo.

Umcwaningi: Ngiyabona.
Umbambiqhaza: Uma kunesimo esiphuthumayo manje ngeke ngakwazi ukuthola i*psychologist*. Phezu kwalokho, uma ngidluliswa wudokotela noma uma ngifisa ukuphindela kumele ngidluliswe yilowo dokotela. Kumele sikwazi ukuzenzela amaphoyinti. Akumele kuthiwe ama-*psychologist* eDinizulu

atholakala ngoLwesithathu, uma ngikhona kuwuMsombuluko, kutholakale ukuthi ngizibulele ngoLwesibili. Noma ngabe ngidluliswe wudokotela okanye ngiziyele mina kumele ngikwazi ukuthola usizo uma sengifikile ngithi ngiyagula manje, kumele basisize njalo hhayi ngohlelo olubekiwe. Noma kuthiwa anginalo ikhadi ngaleso skhathi, ikakhulukazi uma sibuzwa ukuthi bekuyimuphi udokotela obesixilongile. Angikwazi ukuthi yimuphi udokotela obengixilongile ngaleso sikhathi kodwa kumele ukuthi ngikhona kwi system, kodwa kungaba wusizo uma belalela ngaleso sikhathi. Kumele kube khona ipsychologist isibhedlela nesibhedlela njengabanye odokotela.

Umcwaningi: Zikhona yini ezinye izingqinamba mhlawumbe obhekana nazo usekwi *psychotherapy*?
Umbambiqhaza: Ekuqaleni inking kwawukuzibuza ukuthi kazi lomuntu uzongilalela yini, ngangizwela kakhulu kanti isikhathi sasigijima futhi sisifishane, kodwa ngaqhubeka ngaxoxa ngezingqinamba zami ngagcina sengibohlile kancane kancane.

Umcwaningi: Ngabe i-*psychotherapy* yayenziwa ngolimi lwakho lwebele noma ngolunye ulimi?
Umbambiqhaza: IsiZulu, sasikhuluma ngesiZulu.

Umcwaningi: Ngiyacabanga akubanga khona imincele ekuxhumaneni. Yikuphi ongakuphawula maqondana nobuyonincwi obusetshenziswa ngo dokotela kumaseshini?
Umbambiqhaza: Ngingathi kungaba ngcono uma ngingakhuluma ne psychologist bese ngiba neqembu lokukhuthazana elinabantu abasesimeni esifanayo nesami ukuze kukhoneke. Ngingabona ukuthi uyazi ukuthi kunjani ukubhekana nesimo esifana nesami, nokuthi kunomunye umuntu osesimeni noma odlule esimeni esinjengesami. Manje kunezinkundla zokuxhumana, mhlawumbe iqembi lika whatsapp, ngoba kwesinye isikhathi siyazwela siding umuntu esingaxoxa naye.

Umcwaningi: Kungasiza, ikakhulukazi labo abake babhekana nesimo esifanayo basizakala.

Umbambiqhaza: Yebo, kungasigqugquzela ikakhulukazi uma ubona ukuthi omunye umuntu uke wadlula esimeni esifanayo.

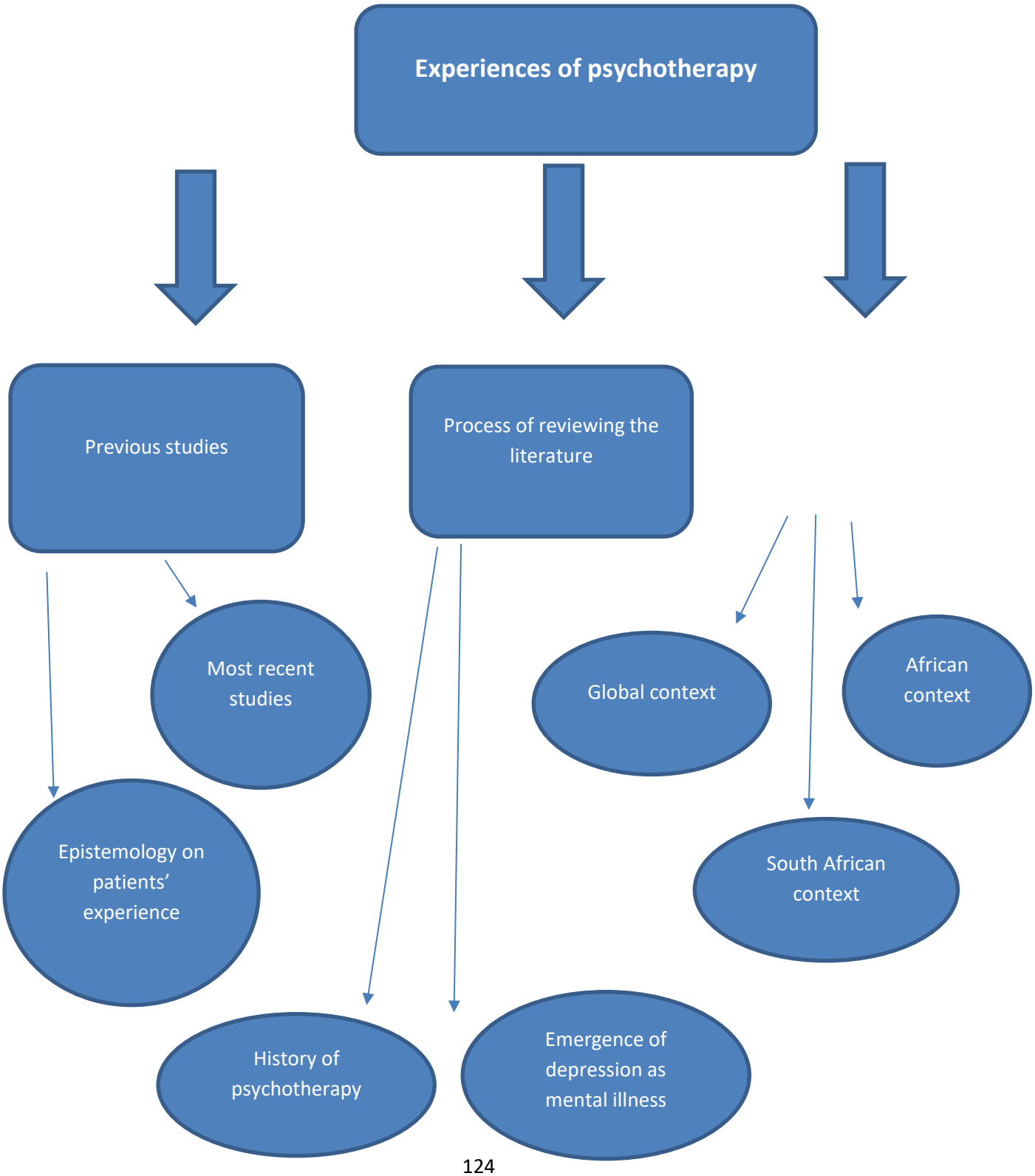
Umcwaningi: Ngokwazi ukuthi lezi yizibhedlela zikahulumeni, ucabanga ukuthi singenzenjani ukuqhakambisa nokwazisa lamaqembu kulabo abathintekayo. Inkunga enkulu kungaba wukuthi, kwenziwa njani ukuqinisekisa imfihlo yeziguli ngaso sonke isikhathi, ake sithi nje ngeke sathi nansi inombolo yokuxhumana neziguli ezinesimo esifana nesakho.

Umbambiqhaza: Lokhu kungenzeka emphakathini lapho uhulumeni engaqondana nemiphakathi. Yimiphakathi eyazi kangcono ngabantu bayo. Ake sithi kunomama oke ashaye ubaba wakwakhe, umphakathi ongathi hamba uye kulowo muntu angasiza, kanti nebandla lingadlala indima enkulu. Kodwa akusiyona yonke into engaxoxwa emasontweni kodwa uma kungahlelwa izinsuku zokuhlangana kukhona okungavulelekelwana ngakho kalula. Ake sithi nje, uma kunobuxhwanguxhwangu emndenini, umphakathi uyena mahluleli wokuqala.

Umcwaningi: Uma kukhona imininingwane eyengeziwe mhlawumbe ofisa ukuyinezezela ngicela ukhululeke ukusithinta ngoba inhloso yalolu cwaningo ukusiza iziguli eziphethwe ukucindezeleka nokunezezela emzimbeni wolwazi ukuze umphakathi usizakale. Ngiyabonga kakhulu ngesikhathi sakho.

Appendix 12

Mind-map for literature review.



Appendix 13: Certificate from the professional editor

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EXPERIENCES OF PATIENTS WITH DEPRESSION WHO ARE RECEIVING PSYCHOTHERAPY IN SELECTED PUBLIC HOSPITALS IN ETHEKWINI DISTRICT, KWAZULU-NATAL/Ntokozo Pearl Ndokweni (21959551)

I am a freelance editor specialising in proofreading and editing academic documents. I confirm that I have edited this dissertation and the references for clarity, language and layout. I used the track changes/review option in Microsoft Word. I returned the document to the author:

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- 16 years' experience in editing theses, research reports, teaching materials, journal articles, newsletters.
- Scribing, recording and transcriptions for workshops, seminars, debates.
- Facilitating and lecturing at Workers' College and Durban University of Technology.
- Master's in Library & Information Science, University of KwaZulu-Natal.
- B.Bibl.(Hons) in Library & Information Science, University of South Africa
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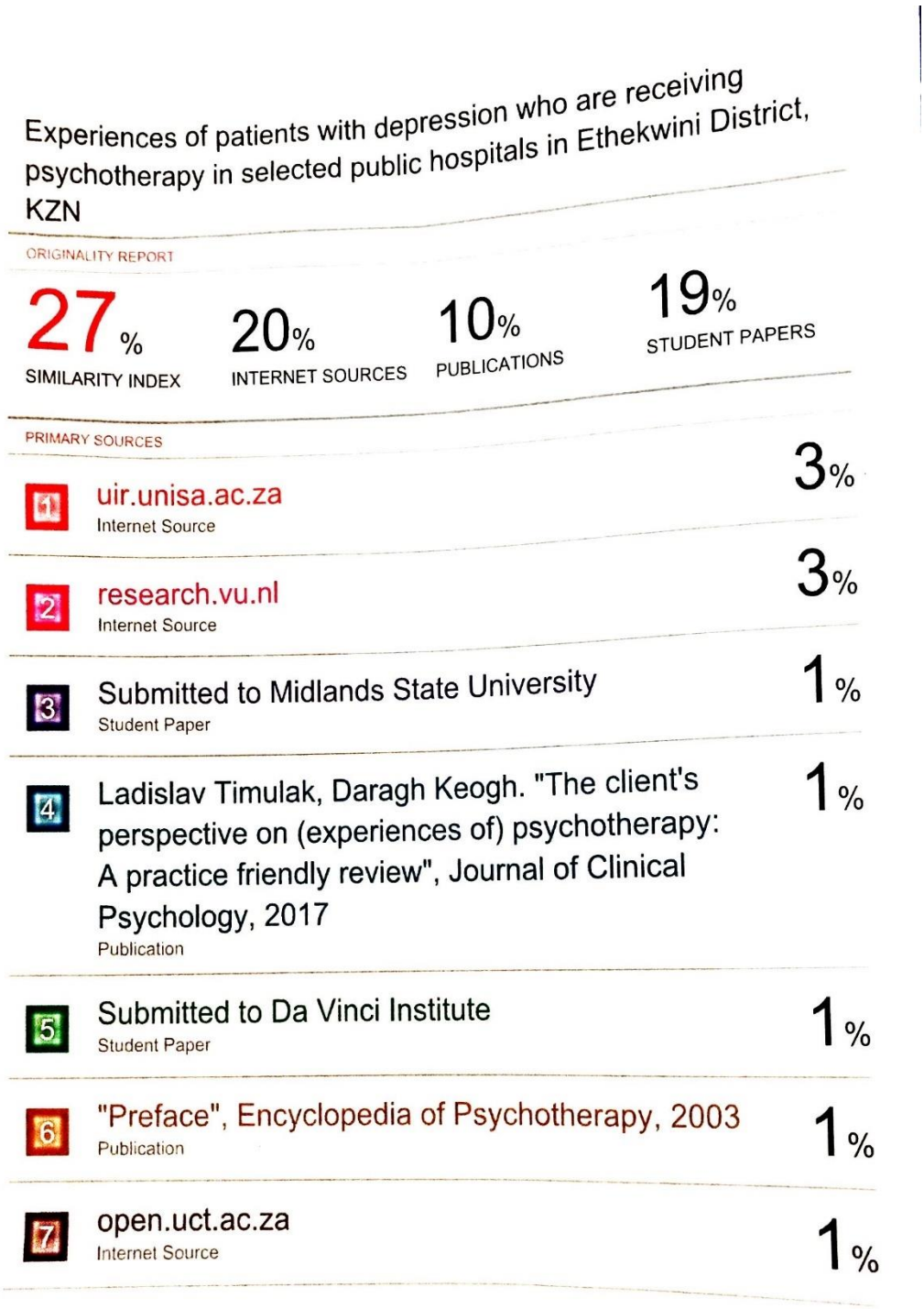
Thara Devi Shah (Director) 26 NOVEMBER 2019

Appendix 14: Turnitin Report.



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