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THE LIVED EXPERIENCES OF THEIR TREATMENT BY ADULT FEMALES WITH DEPRESSION

BY

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DEDICATION

I dedicate this minor dissertation to my loving son. I hope to plant the seed for an eagerness and desire to gain knowledge.

Question everything; and that nothing is ever cast in stone.

Always believe in yourself and your capabilities, and that you can do anything you set your mind to.

Nothing is impossible!
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To God Almighty, who proved to me once again that our God is a living God who answers prayers and that opened doors that no human could possibly open.

To my loving husband, thank you for your amazing support in every single aspect. Thank you for every single meal you cooked, washing and cleaning you did and helping me in every aspect you could. I appreciate every single thing you have done and do for me. You are an amazing husband and father.

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ABSTRACT

Depression has a significant impact on disability, co-morbidity and mortality worldwide. The leading cause of disease-related disability among adult females in the world is major depression. Across all cultures, adult females are more prone and experience depression more frequently than men. Treatment guidelines recommend the continuation of anti-depressants even several months after treatment remission, but there still appears to be low levels of treatment compliance and premature termination of treatment irrespective of recommendations. There are multiple interventions available to improve treatment compliance, but it seems that there is still a need for treatment compliance interventions that are effective.

There are a number of studies available that have explored the lived experiences of depression, but there remain questions relating to improved compliance amongst adult females with depression. The researcher having worked in both the public and private sector as a psychiatric professional nurse have noted across all sectors that depression is still very much treated as a biomedical illness where treatment is given to aid recovery. It has appeared to the researcher that this treatment given is rather "something that is done to" the patients with minimal patient input. When the researcher asked questions such as "why do adult females not comply with their treatment?" majority of the answers were still related to the biomedical model and answerers such as "side-effects of medication". The researcher’s interest was triggered by the attitudes, beliefs and cognitive processes or thought processes why adult females do not comply with their treatment or terminate treatment prematurely. Given the above information, the researcher asked the following research questions: “What is the lived experiences of adult females with depression regarding their treatment?” and “What can be done by the psychiatric nurse to facilitate adult females regarding compliance with their treatment?”

The purpose of the study was to explore and describe the lived experiences of adult females with depression regarding their treatment, and to formulate guidelines to assist the psychiatric nurse to facilitate adult females regarding compliance with their treatment.
A qualitative, exploratory, descriptive, contextual research design and a purposive sampling method were used. Data were collected through phenomenological interviews and the incorporation of the field notes. One central question “How do you experience your treatment?” was asked during the interviews.

Guba and Lincoln’s approach to trustworthiness was adopted and ethical principles were adhered to. Tesch’s eight step analysis technique was used to analyse the textual data systematically.

Three themes emerged from the data that were collected. Firstly, adult females with depression experience their treatment initially as trial and error and eventually as lifesaving. Secondly, adult females experience the therapeutic relationship with the members of the multidisciplinary team as a pertinent component in promoting their mental health and lastly; adult females experience the development of intrapersonal skills and, therefore, realise their responsibility for their own lives. Guidelines were formulated to assist the psychiatric nurse to facilitate adult females regarding compliance with their treatment.
Wêreldwyd het depressie ‘n aansienlike inpak op ongeskiktheid, komorbiditeit en mortaliteit. Die hoofoorsaak van siekte-verwante ongeskiktheid onder volwasse vrouens in die wêreld, is depressie. Oor alle kulture is volwasse vrouens meer geneig en ervaar hulle meer gereeld depressie, in vergelyking met mans. Behandeling riglyne beveel aan dat die gebruik van anti-depressante vir ’n paar maande na remissie moet aanhou, maar daar blyk steeds lae vlakke van behandeling nakoming en voortydige terminasie van behandeling, ongeag van aanbevelings. Daar is vele intervensies beskikbaar om behandeling nakoming te verbeter, maar dit blyk asof daar steeds ‘n behoefte vir effektiewe behandeling nakoming intervensies is.

Daar is ‘n aantal studies beskikbaar wat die beleefde ervarings van depressie eksploreer, maar daar is steeds vrae rondom hoe om nakoming onder volwasse vrouens met depressie te verbeter. Die navorser, wat in beide die publieke en private sektore as ‘n professionele psigiatriese verpleegkundige gewerk het, het in alle sektore agter gekom dat depressie steeds meestal as ‘n biomediese siekte behandel word, waar behandelinge gegee word om gesondheid te bekom. Dit het vir die navorser gelyk asof die behandeling wat gegee word eerder iets is wat “aan die pasiënte gedoen word”, met minimale pasiënt-insette. Wanneer die navorser vrae soos “hoekom is volwasse vrouens nie nakomend met hul behandeling nie” gevra het, het die oorgroote meerderheid van die antwoorde steeds verwant gehou met die biomediese model en antwoorde soos “newe-effekte van medikasie” was verskaf.

Die navorser se belangstelling was geaktiveer deur die gedrag, geloof en kognitiewe of denk-prosesse rondom hoekom volwasse vrouens nie nakomend met hul behandeling nie, of hoekom hulle behandeling voortydig staak. Gegewe die bogenoemde informasie, het die navorser die volgende navorsingsvrae gevra: “Wat is die beleefde ervarings van volwasse vrouens met depressie aangaande hul behandeling?” en “Wat kan deur die psigiatriese verpleegkundige gedoen word om die volwasse vrouens te faciliteer om nakomend met hul behandeling te wees?”
Die doel van die studie was om die beleefde ervarings van volwasse vrouens met depressie aangaande hul behandeling te eksploreer, en om riglyne te formuleer om die psigiatriese verpleegkundige te help om die volwasse vrouens te fasiliteer in terme van nakoming met hul behandeling.

‘n Kwalitatiewe, eksplorere, beskrywende, kontekstuele navorsings-ontwerp en doelgerigte steekproeftrekking metode was gebruik. Data was ingesamel deur fenomenologiese onderhoude en deur die insluiting van veldnotas. Een sentrale vraag “Hoe ervaar jy jou behandeling?” was gedurende die onderhoude gevra.

Guba en Lincoln se benadering tot betroubaarheid was aangeneem en etiese beginsels was gevolg. Tesch se agt-stap analise tegniek was gebruik om die tekstuele data stelselmatig te analiseer.

Drie temas het uit die data wat ingesamel is, verskyn. Eerstens, volwasse vrouens met depressie ervaar hul behandeling aanvanklik as ‘probeer en fouteer’, maar uiteindelik beleef hulle dit as lewensreddend. Tweendens, volwasse vrouens ervaar die terapeutiese verhouding met die lede van die multidisiplinêre span as ‘n pertinente komponent in die bevordering van hul geestesgesondheid, en laastens, volwasse vrouens ervaar die ontwikkeling van interpersoonlike vaardighede en realiseer dus hul verantwoordelikheid vir hul eie lewens. Riglyne was geformuleer om die psigiatriese verpleegkundige te help om die volwasse vrouens te fasiliteer om nakomend met behandeling te wees.
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CHAPTER ONE
RATIONALE AND OVERVIEW

“Life is a succession of lessons which must be lived to be understood.”
— Ralph Waldo Emerson

1.1 BACKGROUND AND RATIONALE

Mental illnesses, such as depression, are some of the most expensive and disabling conditions and represent five of the top leading causes of disability worldwide for both men and women. Mental disorders are common and affect more than twenty-five percent of all people at some time during their lives. It is estimated that the total Disability-Adjusted Life Years (DALY’s) will increase from twelve percent in 2000 to fifteen percent in 2020 (WHO Report of 2001 on Mental Health, 25, 27).

Ross and Goldner (2009:558) also indicate that mental illness is a major burden to global disease and significantly impact on disability, co-morbidity and mortality. The rate of depression is rising rapidly and by the year 2020, depression will have risen to become the second greatest cause of disability, second only to ischaemic heart disease (Keyes & Goodman, 2006:3; Michael & Yapko, 2009:xiii; Yeung, Feldman & Fava, 2010:1).

Major depression is the leading cause of disease-related disability among adult females in the world today (Fogel & Woods, 2008:254; Keyes & Goodman, 2006:22). Adult females experience depression two to three times more frequently than men, and ten to fifteen percent of woman can experience clinical depression at some point in their lives that will last an average of thirteen years (Poslusny, 2000:293).

Across all cultures, adult females are more prone to major depression than men (Kneisl & Trigoboff, 2009:414). The risk of developing major depressive disorder ranges from fifteen to twenty-five percent in adult females, versus a lower incidence of eight to fifteen percent for males (Kneisl & Trigoboff, 2014:338; Sadock, Sadock & Ruiz, 2009:1675). There is a gender bias to depression, where it is twice as prevalent in adult females as men (Fogel & Woods, 2008:254; Keyes & Goodman,
According to Shawyer, Meadows, Judd, Marting, Segal and Piterman (2012:2), major depressive disorder is commonly a recurrent condition and sixty percent of patients who had one episode will have another within in two years. Despite this prevalence and impact on global disease, there are still low levels of treatment-seeking, follow-through and compliance with treatment (Ross & Goldner, 2009:558). Sher, McGinn, Sirey and Meyers (2005:564) states that fifty-two percent of patients who take antidepressants do not adhere to treatment, either by missing doses or by prematurely discontinuing pharmacologic therapy. Although depression treatment guidelines recommend continuation of prescribed medication for at least eight months after symptom remission, a staggering fifty to eighty-three percent of mental health care patients either discontinue their medication prematurely or take it too inconsistently to derive any clinical benefit (Aikens, Nease & Klinkman, 2008:23).

Non-compliance with medication is a problem and common practice among mental health patients, despite instructions to take their medication as prescribed. Most people do not realise the importance of treatment, and many patients will prematurely stop taking their medications due to a variety of reasons or barriers (Volipicelli, Pettinati, McLellan & O'Brien, 2001:92-93). There is an apparent under utilisation of available treatments and this can be contributed to barriers such as demographic variables (for example: gender, socio-economic status and education), illness-related factors (for example: age of onset, type and severity of symptoms), and beliefs about mental illness and stigma (Marques, LeBlanc, Timpano, Jenike & Wilhelm, 2010:471).

According to Malpass, Shaw, Sharp, Walter, Feder, Ridd and Kessler (2008:155), the prescribing of antidepressants has increased threefold since 1991, and there is evidence that while many patients accept a prescription, one in three do not complete their treatment. Factors such as patient beliefs influence the taking of medication. Kneisl and Trigoboff (2009:866) account non-compliance to factors such as experiencing problems with prescribed psychotropic medications, the severe level of symptomatology, and negative effective of treatment on the patient’s adjustment.
Lastly, there are also factors such as decreased motivation to collaborate treatment, the effect of medication on the user’s interpersonal relationships, lack of support from significant others, attitudes and beliefs that may contribute to patients not complying with treatment.

According to DiMatteo, Haskard-Zolnierek and Martin (2012:77) interventions aimed at improving treatment adherence are not hard to find. What is more difficult is finding ones that work. Less than half of published compliance-enhancing interventions actually demonstrate improved compliance or enhanced patient outcomes.

1.2 RESEARCH PROBLEM

While there has been some studies that have explored the lived experiences of depression that have provided abundant descriptions of the despair experienced, current research asking adult females about their treatment and barriers to treatment, remains sparse (Bilszta, Ericksen, Buist & Milgrom, 2010:45). According to Aikens, et al. (2008:24), studies to promote treatment compliance have delivered disappointing findings. A better understanding of treatment beliefs may help improve patient-centeredness of depression care and can suggest new intervention strategies. O’Brien and Fullagar (2008:9) add that there are still questions regarding the gender dimension of adult females’ experiences of depression and understanding of recovery goes beyond the pharmacological or the therapeutic.

The researcher, having worked in both the public and private sector as a psychiatric professional nurse, noted across all sectors that depression is still very much treated as a biomedical illness where treatment is given to aid recovery. It appeared to the researcher that this treatment given is rather “something that is done to” the patients with minimal patient input. When the researcher asked questions such as “why do adult females not comply with their treatment?” the majority of the answers were still related to the biomedical model and answers such as “side-effects of medication”. The researcher’s interest was triggered by the attitudes, beliefs and cognitive processes or thought processes of why adult females do not comply with their
treatment or terminate treatment prematurely. Given the above information, the researcher asked the following questions:

- What are the lived experiences of adult females with depression regarding their treatment?

- What can be done by the psychiatric nurse to facilitate adult females regarding compliance with their treatment?

1.3 RESEARCH PURPOSE

The overall purpose of the study is to explore and describe the lived experiences of adult females with depression regarding their treatment and to formulate guidelines to assist the psychiatric nurse in facilitating adult females regarding compliance with their treatment.

1.4 RESEARCH OBJECTIVES

The objectives of this study are:

- To explore and describe the lived experiences of adult females with depression regarding their treatment.

- To formulate guidelines to assist the psychiatric nurse in facilitating adult females regarding compliance with their treatment.

1.5 PARADIGMATIC PERSPECTIVE

In this study the researcher's assumptions will be based on the Theory for Health Promotion in Nursing of the University of Johannesburg (Department of Nursing Science: University of Johannesburg, 2010:4-8). This paradigm focuses on all dimensions of the whole person, namely the body, mind and spirit in the internal and external environments. This paradigm also refers to the patient as an individual who functions in a holistic manner within the family and community. The psychiatric
nurse, when providing psychiatric nursing care, will take into consideration the needs of the individual, the family and the community, because patients described in this study are also part of the family and the community.

The researcher’s assumptions will be related to patients, their families and the community. These assumptions will be divided into meta-theoretical, theoretical and methodological categories respectively.

### 1.5.1 Meta-theoretical assumptions

Meta-theoretical assumptions include persons, psychiatric nursing, mental health and the environment.

#### 1.5.1.1 Persons

The term ‘persons’ refer to the participants, their families and the researcher. The whole person embodies dimensions of body, mind and spirit. The person functions in an integrated, interactive manner with their internal and external environment (Department of Nursing Science: University of Johannesburg, 2010:4). In this study, the females with depression are seen as holistic beings that have multi-facets and are complex beings with a body, mind and spirit. These adult females do not function in vacuum, but in an integrated, interactive manner with their internal and external environment. These interactions contribute to their lived experience of depression and their treatment.

#### 1.5.1.2 Psychiatric nursing

‘Psychiatric nursing’ is an interactive process where the psychiatric nurse as a sensitive and therapeutic professional mobilises resources in order to facilitate the promotion of health (Department of Nursing Science: University of Johannesburg, 2010:4). In this study, the psychiatric nurse forms part of the multi-disciplinary team and contributes to how females with depression understand and comply with their treatment.
1.5.1.3 Mental health

‘Mental health’ is a dynamic, interactive process in the patient’s internal and external environment. The patterns of interaction between patients with their internal and external environment determine their health status as an integral part of health (Department of Nursing Science: University of Johannesburg, 2010:5). The adult females in this study who comply with their treatment for depression, aid in their mental health. However, it is not only this mere compliance but their experience of their treatment and their external environment that can either aid or hinder this compliance.

1.5.1.4 Environment

This concept encompasses both the internal and external environment. The environment of the patient is multidimensional. The internal environment comprises of the body, mind and spirit, while the external environment consists of the physical, social and spiritual dimensions (Department of Nursing Science: University of Johannesburg, 2010:5). Adult females with depression embody these dimensions of the body, mind, and spirit, and are in constant interaction with their internal and external environment. Their external environment includes the environment in which they live and work, where they are in constant interaction with their family, friends, work colleagues and other people they come into contact with every day. These interactions affect their internal environment of the body, mind and spirit and contribute to how they experience having depression and their treatment.

1.5.2 Theoretical assumptions

Theoretical assumptions consist of nursing theories, theoretical assumptions and definitions.

1.5.2.1 Nursing theory

The underlying nursing theory in this study is the Theory for Health Promotion in Nursing (Department of Nursing Science: University of Johannesburg, 2010:4-8).
However, the theory will be bracketed during the data collection and will be used after the data analysis has been completed.

1.5.2.2 Theoretical assumptions

Patients are holistic beings who function in an integrated biopsychosocial manner to achieve wholeness. Patients interact holistically (mind, body and spirit) with their internal and external environment. In the Theory for Health Promoting in Nursing approach, individuals focus simultaneously on the spiritual, mind, physical and social aspects of wholeness (Department of Nursing Science: University of Johannesburg, 2010:4-8).

The psychiatric nurse, as a sensitive and therapeutic professional, facilitates the promotion, maintenance and restoration of the mental health of the patient, through the health delivery system. Promotion, maintenance and restoration of mental health require the mobilisation of all resources in the environment of the patient (Department of Nursing Science: University of Johannesburg, 2010:4-8).

1.5.2.3 Theoretical definitions

Definitions that will be utilised in this study will be concurrent with the Theory of Health Promotion in Nursing (Department of Nursing Science: University of Johannesburg, 2010:4-8).

a) Lived experiences

In phenomenological research, the researcher identifies the essence of human experiences concerning a phenomenon. Understanding the lived experiences marks phenomenology as a philosophy as well as a method and the procedure involves studying a small number of participants. In this process, the researcher brackets her experiences in order to understand those of the participants in the study (Creswell, 2003:15). The relevance of the lived experience was the first-hand experiences of adult females with depression and how they experience their treatment. These experiences were both positive and negative.
b) Adult

Sadock and Sadock (2003:41) define ‘adults’ as persons between the ages of twenty and sixty-five. For the purpose of this study, ‘adults’ will include adult females between the ages of twenty-one and sixty-five years old.


c) Depression

The DSM-IV-TR, according to Uys and Middleton (2010:364) and Kneisl and Trigoboff (2009:406), classify ‘depression’ as having the following five symptoms most of the day, almost every day: a depressed mood, anhedonia, changes in weight, changes in sleep patterns, psychomotor agitation or retardation, fatigue, feelings of worthlessness or guilt, decreased concentration, and recurrent thoughts of death or recurrent suicidal ideation. For the purpose of this study, ‘depression’ will include the depressive disorders namely; major depression (single or recurrent), dysthymia and depression not otherwise specified. At the time the research data were gathered, the DSM-5 was not yet in use and DSM-IV-TR was thus applicable to this study.

d) Treatment

‘Treatment’ includes modalities such as hospitalisation, psychotherapy and pharmacotherapy (Sadock & Sadock, 2003:560). In this study, the experiences adult females with depression had with their treatment, include their experiences with medication, psychotherapy and being admitted to a psychiatric hospital.

1.6 RESEARCH DESIGN AND METHOD

In order to meet the aims and objectives of the proposed study the researcher’s primary task is to decide on an appropriate research design or methodology. The chosen design will direct the selection of a population, procedures for sampling, methods of measurement and plans for data collection and analysis (Burns & Grove, 2009:219).
The researcher will adopt a qualitative, exploratory, descriptive and contextual research design. The researcher intends to explore the lived experiences of adult females with depression regarding their treatment.

The research method will be carried out in two phases, which are described below.

1.6.1 Phase one: Exploration and description of the lived experience of adult females with depression of their treatment

In phase one the population and sample, data collection and data analysis will be discussed.

1.6.1.1 Population and sample

A ‘population’ is the entire aggregation of cases in which a researcher is interested. ‘Sampling’ refers to the process of selecting a portion of the population to represent the entire population, whereas a ‘sample’ is a subset of population elements (Polit & Beck, 2010:306-307). The accessible population for this study is adult females with depression receiving active treatment.

The target population will meet the following criteria:

- Adult females between the ages of 20 and 65 years.

- Diagnosed with a depressive disorder such as major depression (single or recurrent), dysthymia and depression not otherwise specified.

- Receiving active treatment.

a) Sampling

The researcher will use purposive sampling and will continue to find participants until data saturation occurs. The researcher has chosen purposive sampling as this
method will allow her to obtain the information she is seeking (Green & Thorogood, 2009:138).

b) Saturation

Data saturation occurs when themes and categories in the data become repetitive, such that little new information can be gleaned from further data collection (Polit & Beck, 2010:79).

1.6.1.2 Data collection

A phenomenological, subjective, in-depth interview was conducted using an audio recorder. Audio recordings were transcribed verbatim. During data collection the researcher used intuiting to actually look at the phenomena, and bracketing to avoid bias in the research (Burns & Grove, 2009:529; Green & Thorogood, 2009:14). Field notes were taken during and following data collection to describe the researcher’s own observations and experiences during the interviews (Houser, 2012:425). See the full description in Chapter Two.

1.6.1.3 Data analysis

The tape-recorded interviews were transcribed verbatim and then analysed using Tesch’s open coding method, which consists of eight steps of data analysis (Creswell, 2003:192-193) in order to develop themes, categories and subcategories. The focus of the data analysis was on the adult females’ lived experience of depression and their treatment. An independent coder was used and a consensus discussion was held with the researcher on the identified themes. The results were described and supported by a literature control. See the full description in Chapter Two.
1.6.2 Phase two: The description of guidelines to assist the psychiatric nurse to improve adult females’ compliance with their treatment

The results of phase one were utilised to describe guidelines to assist the psychiatric nurse to improve adult females’ compliance with their treatment.

1.7 ETHICAL CONSIDERATIONS

Nursing research must not only be able to generate or refine knowledge, but the development and implementation of such research should also be ethically acceptable. The ethical acceptability of the research should apply first of all to the people directly involved in it, but also to the people involved in carrying out the research (Uys & Basson, 2000:97). Accordingly, the researcher obtained permission in writing to conduct the study at a private psychiatric hospital in Johannesburg (see Appendix 2: Request to conduct research). Furthermore, the researcher respected the participants’ right to privacy, anonymity, confidentiality, self-determination, fair treatment and protection from harm and discomfort.

1.7.1 Right to privacy

Privacy is the freedom an individual has to determine the time, extent and general circumstances under which private information will be shared with or withheld from others (Burns & Grove, 2009:194). To protect the participants’ privacy, the researcher obtained informed consent from the participants and allowed them to participate voluntarily. They were assured that their information would not be misused to embarrass or humiliate them. Only data necessary for achieving the objectives of the study were obtained. The researcher did not ask participants’ names during the recording of the interviews and audiotapes were kept under lock and key, with only the researcher, supervisors and independent coder having access to the data collected. After transcription, independent decoding and examination, the audiotapes will be destroyed two years after the completion of this research study.
1.7.2 Right to confidentiality and anonymity

‘Confidentiality’ entails that no information provided by a participant should be divulged or made available to any other person (Polit & Beck, 2010:129). ‘Anonymity’ refers to the insurance that it is not possible to relate particular data to a particular person or institution (Polit & Beck, 2010:129). Confidentiality and anonymity was ensured through the use of codes instead of names, placing data under lock and key, and assurance to the participants that only the researcher, her supervisors and independent coder will have access to the data.

1.7.3 Right to self-determination

The right to self-determination is based on the ethical principle of respect for persons and indicates that people are capable of controlling their own destiny. They should be treated as autonomous agents, who have the freedom to conduct their lives as they choose without external controls (Burns & Grove, 2009:189). In this study, the participants’ right to self-determination was ensured by explaining the purpose, significance and potential benefits of the study to them, by obtaining their informed consent and emphasising that participation was free and voluntary with the right to withdraw from the study at any time without penalty.

1.7.4 Right to freedom of choice and protection from discomfort and harm

The right to protection from discomfort and harm is based on the ethical principle of beneficence. The principle of beneficence states that one should do good and, above all, do no harm (Burns & Grove, 2009:198). Participants had the opportunity to volunteer to participate in the study or could choose not to participate or withdraw from the study if they felt they needed to do so.

1.7.5 Informed consent

The four elements necessary for informed consent are disclosure of essential information to the participant, participant’s understanding of this information, capacity to give consent, and voluntarily providing consent to participate (Burns & Grove,
With these four elements in place, the researcher asked the participants to read and sign a consent form at the beginning of the process and ensured that they understood the information (see Appendix 4: Consent form to participate in the research study). Consent was also requested from the participants to audio record the interviews (see Appendix 5: Consent form for permission to audiotape the interview). The audiotapes were kept under lock and key in a cupboard in the researcher’s office. Only the researcher, supervisors and independent coder had access to the audiotapes. The audiotapes will be destroyed two years after publication of the research. Participants were, furthermore, reminded of their right to withdraw at any stage without prejudice or penalty. Ethical approval was also obtained from the University of Johannesburg, Faculty of Health Sciences, Academic Ethics Committee, AEC39-01-3013. (See Appendix 1).

1.8 MEASURES TO ENSURE TRUSTWORTHINESS

The researcher will apply Lincoln and Guba’s framework (Polit & Beck, 2010:492) to ensure trustworthiness. The four strategies of the framework entail:

- Truth-value, which is established by credibility.
- Applicability, which is ensured by transferability.
- Consistency, which is ensured by dependability.
- Neutrality, which is ensured by confirmability.

Measures to ensure trustworthiness will be discussed in depth in Chapter Two.

1.9 DIVISION OF CHAPTERS

This minor dissertation is divided into four chapters. In Chapter One the rationale and overview of the study was covered. In Chapter Two the research design and method will be discussed. In Chapter Three a discussion on the research findings will be provided and the literature review will be covered. In the final chapter,
Chapter Four, the guidelines, conclusions, evaluation of the study and the recommendations will be discussed.

1.10 SUMMARY

In Chapter One an overview of the research study was provided. The background and rationale for the study was offered and the problem statement, research question, research purpose, paradigmatic perspective and assumptions, as well as the research approach and method were described. In Chapter Two the research design and method will be discussed in greater detail.
CHAPTER 2
RESEARCH DESIGN AND METHOD

“Nothing ever becomes real ‘til it is experienced.”
— John Keats

2.1 INTRODUCTION

In this chapter a detailed plan and a description of the rationale, objectives, research design and methods of the study will be given.

2.2 RATIONALE

According to Bouchard and Shih (2013:424), research studies consistently conclude that adult females are twice as likely to develop depression versus their male counterpart. Even though there is a high prevalence of depression in females (Keyes & Goodman, 2006:22), the levels of treatment-seeking and compliance remain low (Sher, et al. 2005:564).

According to DiMatteo, et al. (2012:77), interventions to improve treatment compliance is abundant, but the minority of these published interventions actually demonstrate improved adherence. A more critical understanding of adult females’ experiences of depression and recovery is needed to aid well-being and bring about the direction for treatment (O’Brien & Fullager, 2008:6).

2.3 RESEARCH PURPOSE AND OBJECTIVES

The overall purpose of the study is to explore and describe the lived experiences of adult females with depression regarding their treatment, and to formulate guidelines to assist the psychiatric nurse in facilitating adult females regarding compliance with their treatment.
The objectives of this study are:

- to explore and describe the lived experiences of adult females with depression regarding their treatment; and

- to formulate guidelines to assist the psychiatric nurse in facilitating adult females regarding compliance with their treatment.

2.4 RESEARCH DESIGN

According to Burns and Grove (2009:41), the research design is the blueprint for conducting a study that maximizes relative control over factors that could interfere with a study’s desired outcome of findings. The research design must be developed specifically for the study to be undertaken.

The researcher adopted a qualitative research design, which is exploratory, descriptive and contextual in nature (Burns & Grove, 2009). In this study, the lived experience of adult females with depression regarding their treatment was explored and described.

2.4.1 Qualitative research

Qualitative research is holistic, and the purpose of qualitative research is to examine the whole rather than the individual parts. The qualitative researcher is more interested in understanding complex phenomena (Burns & Grove, 2009:8). Creswell (2003:181-182) defines a ‘qualitative study’ as an inquiry process of understanding a social or human problem, based on building a complex, holistic picture, formed with words, reporting the detailed views of informants, and is conducted in a natural setting.

Qualitative research aims to generate knowledge concerned with meaning and discovery. Predominant in these studies are inductive and dialectic reasoning (Burns & Grove, 2009:23). With inductive reasoning, reasoning from the specific to the general in which particular instances are observed and then combined into a larger
whole or general statement, takes place (Burns & Grove, 2009:703). With dialectic reasoning, the holistic perspective is involved in which the whole is greater than the sum of the parts. It examines factors that are opposites and makes sense of them by merging them into a single unit or idea that is greater than either alone (Burns & Grove, 2009:697).

The qualitative researcher has an active part in the study, and the findings from the study are influenced by the researcher’s values and perceptions. Thus, the research approach is subjective, but the approach assumes that subjectivity is essential to the understanding of human experiences (Burns & Grove, 2009:23).

In this study, the researcher described and gave meaning to the lived experience of participants regarding their treatment and how to improve their compliance with their treatment.

2.4.2 Exploratory research

Exploratory research begins with a phenomenon of interest, but rather than simply observing and describing it, the full nature of the phenomena is investigated. The manner in which the phenomenon has manifested and factors related, including potential factors that might be causing it, are investigated. Through this exploration, light is shed on various ways in which the particular phenomenon is manifested and its underlying processes (Polit & Beck, 2010:22). Exploratory studies are not intended for generalisation to large populations but are designed to rather increase the knowledge of the field or a particular phenomenon (Burns & Grove, 2009:359).

In this research study, the researcher explored and described the lived experiences of adult females with depression regarding their treatment, and formulated guidelines to assist the psychiatric nurse in facilitating adult females regarding compliance with their treatment.
2.4.3 Descriptive research

The purpose of descriptive research is to obtain complete and accurate information about a phenomenon through observation, description and classification in order to provide new information on a phenomenon (Polit & Beck, 2010:236). According to Burns and Grove (2009:696), descriptive research provides an accurate portrayal or account of the characteristics of a particular individual, event or group in real-life situations for the purpose of discovering new meaning, describing what exists, determining the frequency with which something and categorising information.

In this research study, information was obtained through observation, description and classification of characteristics of factors that impede or improve compliance with treatment.

2.4.4 Contextual research

According to Creswell (2003:62), ‘context’ means the field at the site where the participants experience the issue or problem under study. This study was contextual in nature as the aim was to describe and explore, and attempt to understand and give meaning to the lived experience of adult females with depression and their treatment. The researcher sought to understand and give meaning of how the specific adult females in this study, in their unique and specific context, experienced their treatment and to formulate guidelines that apply to this context.

2.5 Research Method

The study was conducted in two phases that are described below:

- Phase one: Exploration and description of the lived experience of adult females with depression regarding their treatment.

- Phase two: The formulation of guidelines to assist the psychiatric nurse to facilitate adult females regarding compliance with their treatment.
2.5.1 Phase one: Exploration and description of the lived experience of adult females with depression regarding their treatment

In this qualitative study, a descriptive phenomenological method of inquiry was used. According to Roberts (2013:215), phenomenology stems from philosophy and provides a structure for a method of research. The aim of phenomenological inquiry is to describe a lived experience by providing meanings and essences to these experiences. Descriptions of lived experiences were obtained from the participants through one-to-one interviews, which was then transcribed and analysed for themes and meanings, allowing the experience to be better understood.

This phase included population and sampling, data analysis, data collection through interviews, data analysis, and literature control.

2.5.1.1 Population and sample

A ‘population’ is the entire set of individuals that have some common characteristics. It includes all the cases in which the researcher is interested (Polit & Beck, 2010:75, 306; Houser, 2012:177). Samples are drawn to represent populations in a research study as it is rarely possible or necessary to study an entire population. A ‘sample’ refers to the subset of a population that the researcher will study. Samples are thus selected carefully in order to represent an entire population (Houser, 2012:177). Through non-probability purposive sampling, the researcher will continue to find participants until data saturation occurs (Green & Thorogood, 2009:138).

In this study, the sample was taken from the population that met the sampling criteria for the research study. The target population was adult females, with depression who were receiving treatment.

2.5.1.2 Sampling criteria

With the sampling criteria, the researcher indicates those characteristics that are needed in participants for the specific study, and also provides a rationale for selecting these types of participants in order to obtain essential data for the research
study. The sampling criteria were developed from the research problem, the research purpose and the review of literature (Burns & Grove, 2009:344). The sampling criteria for this study were inclusion sampling criteria; meaning that the criteria are those characteristics that a participant should possess to be part of the target population (Burns & Grove, 2009:345).

The inclusion sampling criteria for this study are set out below.

- Adult females between the ages of 20 and 65.

- The average age of onset of depression is in the mid-twenties although it can occur at any age (Kneisl & Trigoboff, 2009:405). The mean age of onset for major depressive disorders is about forty years; whereas fifty percent of patients gave an onset between the ages of twenty and fifty (Sadock & Sadock, 2003:536).

- Diagnosed with a depressive disorder such as major depression (single or recurrent), dysthymia and depression not otherwise specified. Studies over the last three decades consistently ascertained a higher rate of lifetime depression (that includes major depression and dysthymia) in adult females (Parker & Brotchie, 2010:429).

- On active treatment for depression.

2.5.1.3 Saturation and sampling size

In qualitative research, the focus is on the quality of information obtained from the participants versus the size of the sample. The number of participants in a qualitative study is adequate when saturation of information is achieved in the study area (Burns & Grove, 2009:361). Data saturation occurs when additional sampling provides little new information (Burns & Grove, 2009:361; Polit & Beck, 2010:321).

In phenomenological studies, a small sample size is selected since large samples can overwhelm the researcher with data. A purposive homogenous sample is necessary so that themes can be identified from these specific groups who
experienced a particular phenomenon (Roberts, 2013:216). In this research, the phenomenon is adult females with depression’s lived experience of their treatment.

The researcher stopped seeking additional participants when theoretical data saturation was achieved.

2.5.1.4 Role of the researcher

Qualitative research is interpretative research, where the inquirer is involved in a sustained and intensive experience with the participants. This introduces a range of strategic, ethical and personal issues into the qualitative research process. With these concerns in mind, inquirers explicitly identify their biases, values and personal interests about their research topic and process (Creswell, 2003:184).

In varying degrees the researcher influences the participants being studied and vice versa. The mere presence of the researcher may alter the behaviour of the participant. In qualitative research it is considered to be a natural and necessary element of the research process (Burns & Grove, 2009:543). The researcher used the process of ‘bracketing’ during data collection. According to Roberts (2013:215), ‘bracketing’ is the process whereby researchers suspend their own preconceptions, beliefs or prejudices so that they do not affect the interpretation of the participants’ experiences.

Furthermore, according to Burns and Grove (2009:543), the researcher’s personality is a significant factor in qualitative research; skills in empathy and intuition should be cultivated. To interpret the participant’s experience, the researcher needs to become closely involved in the participant’s experience. It is necessary for the researcher to be open to the perceptions of the participant, rather than to attach her own meaning to the experience. Participants being studied often participate in determining research questions, guiding data collection and interpreting results.
2.5.1.5 Data collection

The methodological process of accumulating information relating to the objectives and research questions of a research study is referred to as data collection (Burns & Grove, 2009:695). In a qualitative study data collection occurs simultaneously with data analysis, and makes this a complex process. The collection of data is not a mere mechanical process that can be completely planned before it is initiated. The researcher as a whole person is completely involved in interacting, reacting, perceiving, reflecting, attaching meaning and recording (Burns & Grove, 2009:507-508).

Interviews involve verbal communication during which the subject provides information to the researcher (Burns & Grove, 2009:403). Data is collected through interviews, whereby the research interacts directly with the participant one-on-one (Houser, 2012:239). Furthermore, in an in-depth interview the researcher sets the agenda in terms of the topic(s) covered, but the interviewee’s responses determine the kinds of information produced about those topic(s) and the relative importance of each of them (Green & Thorogood, 2009:94).

In this study, data were collected through in-depth interviews. The interviews were face-to-face, one-on-one, at a suitable, quiet area of the participant’s choice and did not exceed one hour. The interviews were recorded on audiotape and were later transcribed for analysis. These audiotapes will be kept for a period of two years with only the researcher and supervisors having access to them. After the period of two years, the audiotapes will be destroyed. One question was asked to all participants:

“How do you experience your treatment?”

The wording of the questions is critical in an interview. Wording should be clear and words with double meaning should be avoided. The use of open-ended questions allows the participant to provide more detailed information (Houser, 2012: 239). In-depth interviews involve active listening which contributes to fewer incidents of misunderstanding and the gathering of more accurate information. It begins with encouraging participants to tell their story in an authentic way. By using applicable
questions the participants are helped to tell their story and to obtain the relevant information (Arnold & Underman Boggs, 2011:179,181).

In this research study, the following communication skills and techniques were used to encourage participants to share information regarding the study subject, as listed below:

a) **Minimal cues and leads**

Minimal cues transmitted through body actions (for example; smiling, nodding and leaning forward) encourage the participants to tell their story. By not detracting from the participant’s message and by giving permission to tell the story as the participant sees it, minimal cues promote participant comfort in sharing information. Short phrases such as “go on” or “and then” are useful prompts that lead to communication (Arnold & Underman Boggs, 2011:184-185).

b) **Clarification**

Clarification seeks to understand the message of the participant for more information and elaboration on a point (Arnold & Underman Boggs, 2011:185).

c) **Restatement**

Restatement is used to broaden a participant’s perspective or when the researcher needs to provide a sharper focus on a specific part of the communication. It is effective when a participant seems stuck in a repetitive line of thinking (Arnold & Underman Boggs, 2011:186).

d) **Paraphrasing**

Paraphrasing is a response strategy used to check whether the researcher’s translation of the participant’s words is an accurate interpretation of the message (Arnold & Underman Boggs, 2011:186).
e) **Reflection**

Reflection focuses on the emotional implication of a message. This listening response helps the participant clarify important feelings and experience them with their appropriate intensity in relation to a particular situation or event (Arnold & Underman Boggs, 2011:186).

f) **Summarisation**

This strategy is used to review content and process. Summarisation pulls several ideas and feelings together from one interaction (or a series of interactions) (Arnold & Underman Boggs, 2011:186).

g) **Silence**

Silence, used deliberately and judiciously, is a powerful listening response. Intentional pauses can allow the client to think. A short pause also lets the researcher step back momentarily and process what she has heard before responding (Arnold & Underman Boggs, 2011:187).

h) **Observation and field notes**

Observations of body language, the surroundings, and other factors are also an important part of the data collection. These are referred to as field notes, and they enrich the data interpretation process with detailed descriptions of the context, environment, and nonverbal communications. These observations are generally inserted into the transcripts as soon as possible to ensure they are recollected correctly and completely (Houser, 2012:425).

**2.5.1.6 Data analysis**

Data analysis is conducted to reduce, provide structure, organise and give meaning to the data or information that is collected during the research study (Burns & Grove, 2009:695; Polit & Beck, 2010:463). According to Polit and Beck (2010:464), the
analysis of qualitative data is an active and interactive process. The researcher scrutinises the data carefully and deliberately, often reading data over and over in search for meaning and deeper understanding. Insights and theories cannot emerge until the researcher becomes completely familiar with their data. It includes the process of fitting data together and making the invisible obvious.

After transcribing the recorded interviews, the following eight steps of Tesch’s analysis technique (Creswell, 2003:192) was used to analyse the textual data systematically. This analysis method included the following eight steps:

1. The researcher carefully read through all the transcriptions to get a sense of the whole. Ideas that came to mind were jotted down.
2. The researcher picked one of the interviews, and while going through the interview asked the following question: “what is this about?” Focus was not on the “substance” of the information but on the underlying meaning.
3. After this had been done with several of the participants’ interviews, a list of topics was made. These topics were then clustered together according to major topics, unique topics and leftovers.
4. This list of topics was taken back to the data. Topics were abbreviated as codes and written next to the appropriate segments of the text.
5. The most descriptive wording for the topics was then found and turned into categories. Thereafter, the list of categories was reduced by grouping the topics and relating them to each other.
6. A final decision then had to be made by the researcher to abbreviate each category and to alphabetise these codes.
7. Data material belonging to each category in place was assembled and a preliminary analysis was performed.
8. Existing data was then recoded where necessary.

An independent coder who has experience in using qualitative data analysis was used to also apply Tesch’s eight steps of analysis. The researcher and independent coder then met for a consensus discussion on the findings.
2.5.1.7 Literature control

According to Burns and Grove (2009:720), literature control is the analysis and synthesis of research sources to generate a picture of what is known and not known about a particular situation. This literature shares with the researcher the results of other studies that are closely related to the study being reported. It also relates a study to the larger ongoing dialogue in the literature about a topic by filling the existing gaps and extending prior studies. Furthermore, a framework is provided for establishing the importance of the study as well as a benchmark to compare the results of other studies (Creswell, 2003:29-30).

In qualitative research, the purpose and timing of the literature control vary according to the type of study to be conducted. The purpose is to convey to the researcher what is currently known regarding the topic of interest but also where the inconsistencies or shortcomings are in the knowledge base (Burns & Grove, 2009:91-92).

In this study, literature control was incorporated at the end of the study. According to Creswell (2003:31), the researcher may incorporate the related literature in the final section of the study, where it is used to compare and contrast with the results (or themes or categories) that have emerged in the study.

2.5.2 Trustworthiness

According to Guba and Lincoln (Krefting, 1991:215), ‘trustworthiness’ is a method of ensuring rigour in qualitative research without sacrificing relevance. Burns and Grove (2009:54) state that rigour is reflected in qualitative research as openness, adherence to the philosophical perspective, and thoroughness of collecting data. In this study, the researcher adopted Guba and Lincoln’s model of trustworthiness in qualitative research (Krefting, 1991:215; Houser, 2012:426), which includes the following four strategies:
• **Credibility**: The results of the study represent the realities of the participants as much as possible.

• **Confirmability**: The researcher attempts to enhance objectivity by reducing bias in method and procedures.

• **Dependability**: Repetition of the study with similar participants in similar circumstances results in consistent findings.

• **Transferability**: Results can be transferred to situations with similar participants and settings.

The four above strategies to ensure trustworthiness and rigour in qualitative research is discussed in detail below.

2.5.2.1 Credibility

This strategy determines the extent to which the findings of the study are a true reflection of what the participants experience. The following steps were applied in the research:

a) **Prolonged engagement**

Prolonged engagement is the process of the investment of ample time in the data collection process so that researchers gain an in-depth understanding of the culture, language, or view of the participants of the study (Houser, 2012:427). This was accomplished in this study by spending time with the participants before the interviews and developing a relationship of trust and by allowing sufficient time for the interviews.

b) **Reflexivity**

According to Houser (2012:426-427), ‘reflexivity’ is a sensitivity to the ways in which the researcher and the research process have collected the data based on
introspection and acknowledgement and the process of becoming aware of any biases. Bracketing is a method used to limit the effects of researcher bias by becoming aware of potential assumptions and preconceived notions. In this study, the researcher set aside bias through self-awareness and by becoming sensitive to the ways in which the researcher and the research process shaped data.

c) Member checking

Member checking is a method of ensuring validity by having participants review and comment on the accuracy of transcripts, interpretations or conclusions (Houser, 2012:428). In this study, this was done during the data collection process where the researcher asked the participants to clarify statements that were made to ensure that the researcher interpreted it correctly.

d) Triangulation

The researcher uses a variety of methods or informants to capture a more complete and insightful picture of the phenomena that are being studied. Triangulation includes a method where at least three sources of information are used to support each major conclusion and this can include data source triangulation, theory triangulation and investigator triangulation (Houser, 2012:427-428). Triangulation was applied in this study by using multiple data sources like various participants (data source triangulation), literature control (theory triangulation) and an independent coder (investigator triangulation) when data were analysed.

e) Peer examination

‘Peer examination’ refers to the researcher’s discussions around the findings and the problems experienced with impartial colleagues who have experience in qualitative research (Krefting, 1991:219). In this study, this was done by the researcher discussing the research process and findings with her supervisors and the independent coder.
f) Structural coherence

The credibility of an argument is enhanced by the establishment of structural coherence. That is the assurance that there are no unexplained inconsistencies between the data and their interpretations. Although data may conflict, credibility is increased if the interpretation can explain the apparent contradiction (Krefting, 1991:220). Throughout this study, the researcher focused on the lived experiences of their treatment by adult females with depression and aimed to provide a holistic picture of all the data collected. All the research results were written within the framework of Nursing Theory for the whole person.

2.5.2.2 Transferability

Transferability is the extent to which qualitative findings can be transferred to other settings (Krefting, 1991:220; Polit & Beck, 2010:111). The following steps were applied in the research:

a) Purposive sample

The selective sampling method that involves the conscious selection by the researcher of certain participants or elements to include in the study (Burns & Grove, 2009:716). Purposive sampling was used in this study by selecting participants who met the inclusion criteria set, in order to provide the information needed.

b) Dense description of results supported by direct quotations from participants

Comprehensive detail is provided for the participants as well as the research contents, setting and process, as this will enable others to determine how transferable the results are (Krefting, 1991:220). This was achieved by a dense description of results supported by direct quotations from the participants in the study, as will be evidenced in Chapter Three. The results were contextualised and supported by the literature control.
2.5.2.3 Dependability

‘Dependability’ refers to the evidence that if the study were to be repeated with the same or similar participants in the same or a similar context, the findings would be similar (Polit & Beck, 2010:492). The following steps were applied in the research:

a) Dependability audit

Dependability can be described as auditability where other researchers can follow the researcher’s steps and come to the same conclusion. This audit trail provides an element of rigour to the study (Boswell & Cannon, 2014:237). In this study, a thorough and conscientious reflection and recording of the decisions that were taken, procedures that were conducted, and questions that were raised, were recorded to make the audit trail possible.

b) Code-recoding of data

Tesch’s eight step analysing technique was used as discussed previously in this chapter (Creswell, 2003:192). An independent coder was also consulted and a consensus meeting was held.

c) Stepwise replication of the research method

A thorough description of the methodology is a way of building a stepwise replication technique into the research (Krefting, 1991:221). Throughout this research study, the researcher intends to describe the steps taken and support them with references to literature. This chapter, in particular, sets out the steps that are to be taken in this research study and further steps will be explained in the chapters where they are featured.

2.5.2.4 Confirmability

‘Confirmability’ refers to objectivity and neutrality of the data, to the degree to which the findings are the product of the focus of inquiry and not figments of the
researcher’s imagination (Polit & Beck, 2010:492). Confirmability represents freedom from bias or neutrality (Boswell & Cannon, 2014:237). The researcher analysed data in a way that kept researcher biases, assumptions and perspectives separate and the review by supervisors mitigated the effects of researcher bias.

2.5.3 Ethical considerations

In this study the researcher will respect the following rights of the participants:

- the right to privacy;
- the right to anonymity;
- the right to confidentiality;
- the right to self-determination;
- the right to fair treatment; and
- the right to protection from harm and discomfort.

The above rights were discussed in detail in Chapter One of this study.

2.5.4 Phase two: The formulation of guidelines to assist the psychiatric nurse in facilitating adult female’s compliance with their treatment

The data that were collected and analysed along with the literature control and triangulation during phase one were used in phase two to formulate guidelines for the psychiatric nurse to assist adult females with depression to comply with their treatment.

The guidelines were based on the research findings.
2.6 CONCLUSIONS, LIMITATION AND RECOMMENDATIONS

The conclusions, limitations and recommendations of this study were based on the research findings. Recommendations were made for nursing practice, education and further research.

2.7 SUMMARY

In this chapter the research design and method in the process of this study were discussed. The methods to ensure the rigour and trustworthiness of the study were also described. In Chapter Three the results of the phenomenological interviews of adult females with depression and their treatment will be provided.
CHAPTER 3
DISCUSSION OF RESEARCH FINDINGS

“The purpose of life is to live it, to taste experience to the utmost, to reach out eagerly and without fear for newer and richer experience.”
— Eleanor Roosevelt

3.1 INTRODUCTION

In the previous chapter, the research design and method for this study were discussed. In Chapter Three an account and discussion of the research findings of the in-depth phenomenological interviews with adult females of their lived experiences with depression and their treatment is given. In this chapter, a literature review is also included to validate the findings of the research study.

3.2 SAMPLE DESCRIPTION

Nine interviews were conducted and data saturation was reached as evidenced by there being no new information (Burns & Grove, 2009:361; Polit & Beck, 2010:321). The participants were purposively selected according to the sampling inclusion criteria for this research study. The participants were all adult females between the ages of 21 and 65 with depression, who were receiving active treatment for their depression. All the participants in this study were admitted to a private psychiatric hospital as a result of their depression symptoms, and required hospital care and containment, but they were all voluntary admissions. These participants were admitted under the Mental Health Care Act no 17 of 2002, Section 25 as a voluntary mental health care user (Mental Health Care Act no 17 of 2002). They were all from a middle to higher socioeconomic class as they were on medical aid and could afford private hospital care, consults and therapy with the multi-disciplinary team in a private setting. They could all speak either English or Afrikaans. The ethnicity of the participants comprised of one Coloured female, one Indian female and seven Caucasian females.
3.3 DESCRIPTION OF THE ENVIRONMENT

The research was conducted in a private psychiatric hospital in Gauteng. The interviews were conducted in either the unit manager’s office or the ECT (Electro Convulsive Therapy) recovery room. These rooms were chosen to ensure privacy during the interviews as these rooms had doors that could close and a sign that read: ‘Do not disturb: session in progress’ was placed outside the door. The researcher purposefully set two chairs, that were used by the participant and the researcher respectively, approximately one to one-and-a-half meters from each other. According to Arnold and Underman Boggs (2011:178), therapeutic conversations typically take place within a social distance of three to four feet. Physical space that includes seating arrangements in which communication occur needs to be planned and a cosy, open seating arrangement encourages interaction (Kneisl & Trigoboff, 2014:176).

One of the participants requested to have the interview in her room while she was sitting in her bed under the blankets as the day of the interview was an exceptionally cold winter’s day and she verbalised that she would feel more comfortable. According to Burns and Grove (2009:362), a natural setting is an uncontrolled, real-life situation or environment. Participants were allowed to select the most convenient or comfortable setting for them.

3.4 ANALYSIS OF FIELD NOTES

The researcher kept a record of her observations and thoughts during the interviews which included personal or reflective notes and descriptive field notes. Field notes enrich the data interpretation process with detailed descriptions of the context, environment and nonverbal communications (Houser, 2012:425). The field notes in this study gave a description of what was observed as well as the reflective thoughts of the researcher, and are discussed below under ‘observation during the interviews’.
3.5 OBSERVATION DURING THE INTERVIEWS

The ethnicity of the participants was recorded. The majority of the participants were Caucasian. There was no deliberate selection of a particular ethnic group by the researcher. The participants were informed of the research study and those willing to participate were included as it was a voluntary study. At the time data were collected the number of Caucasian females admitted to the particular facility where higher compared to other ethnic groups. One of the researcher’s reflective notes considered if and how the results may have been different or the same if a more diverse population with a more diverse ethnic group was used.

Initially, during some of the interviews, some of the participants appeared to have a closed body posture; for example by having crossed legs or crossed arms, or making little or no eye contact. One of the participants turned her chair and her body to the side, away from the researcher. One of the challenges that the researcher faced was that she was not working at the facility where data were collected and did not know or have a prior report with the participants. She attributed this to the participants appearing to have closed body postures at first, but as the interviews progressed and a report was built, the participants seemed more relaxed. The reflective notes of the researcher speculated if other data or themes would have surfaced if she had a better rapport with the participants or if it might have worked in her favor that she was not known.

Not all the participants had the DSM IV-TR Axis I diagnoses of Major Depressive Disorder (Uys & Middleton, 2010:364; Kneisl & Trigoboff, 2009:406). Some of the participants had an Axis I diagnoses of Bipolar Mood Disorder and some had a dual diagnosis, but all the participants in this research study had an Affective Mood Disorder and were admitted to hospital because of a Depressive Episode (Uys & Middleton, 2010:364; Kneisl & Trigoboff, 2009:406).

Post-counselling sessions were held with two of the participants as sensitive themes arose during their interviews. There was also one mental health education session specifically relating to medication and one mental health education session relating to ECT's (Electro Convulsive Therapy).
3.6 DATA COLLECTION AND ANALYSIS

The research study, including the title and the purpose and objectives of the study, were discussed prior to the interviews. The opportunity was made available to the participants for any questions relating to the research study, process or interviews. The researcher emphasised that the participation was completely voluntary and that they could withdraw from the study at any time without any penalty. Emphasis was also placed on the fact that the interviews were completely confidential and who had or would have access to the information, and that feedback on the results of the study would be provided on request. (See Appendix 3 for the letter: Request to conduct research, that was given to each participant).

Informed consent was provided by the participants to conduct the interviews as well as consent to audiotape the interviews (See Appendix 4 and 5 for samples of the two consent forms; Consent form for permission to audiotape the interview and; Consent form to participate in the research study).

Data were collected through in-depth interviews until data saturation occurred as evidenced by there being no new information (Burns & Grove, 2009:361; Polit & Beck, 2010:321). The interviews were conducted in either English or Afrikaans. The same question was asked to all the participants: “How do you experience your treatment?” or the question to the participants that was conducted in Afrikaans: “Hoe ervaar jy jou behandeling?”

These interviews were transcribed verbatim and analysed, and following the phenomenological analysis, descriptive and reflective field notes were also considered in the analysis. Tesch’s eight step coding was used and the expertise of an independent coder was sought. The independent coder holds a post-graduate qualification and has previously been used by the University of Johannesburg for other studies in qualitative research. Subsequently, a consensus was reached between the researcher and the independent coder.
After the data analysis, the literature control was used to compare the findings from this study with literature in order to determine differences and similarities (Burns & Grove, 2009:91). Data is supported by the verbatim quotes of the participants. According to Burns and Grove (2009:532), the actual words the participants use to describe an experience are used when reporting the findings, and themes are then identified and used for structural explanation of the findings.

Data from the research of the participants’ experiences were grouped in major themes and categories. The themes and categories are presented in Table 3.1. The results and findings are discussed and interpreted further in this chapter.

**TABLE 3.1: Overview of themes and categories**

<table>
<thead>
<tr>
<th>THEMES</th>
<th>CATEGORIES</th>
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<tr>
<td>1. Adult females with depression experience their treatment initially as trial and error and eventually as life-saving</td>
<td>1.1 Adult females experience the start of their treatment in the care of general practitioners but comply poorly with prescribed treatment because of a lack of the following:</td>
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<td></td>
<td>• A thorough evaluation of their holistic health needs.</td>
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<td></td>
<td>• A team approach by health care providers.</td>
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<td></td>
<td>• A psycho-educational programme which educates them on their illness.</td>
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<td>• Regular follow-ups.</td>
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<td>• Clinical observations by psychiatric nurses to evaluate and intervene in their adaptation to medicine.</td>
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<td>• Limited knowledge of the side-effects of their medicine.</td>
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<td>1.2 Adult females experience the following factors which lead to their being admitted to a psychiatric facility and starting treatment with a psychiatrist:</td>
<td></td>
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<td>• A suicidal attempt.</td>
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| | • They cannot continue endlessly pretending they
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| are doing fine while having depression.  
• The loss of a job.  
• Concerned loved ones who step in and take them to a psychiatrist or hospital.  
• They realise they need long-term treatment when they see the harm their neglecting of their illness cause their loved ones. | |
| 2. Adult females experience the therapeutic relationship with the members of the multidisciplinary team as a pertinent component in promoting their mental health | 2.1 Adult females experience the multidisciplinary team with the different professional disciplines as working in collaboration with one another:  
• The psychiatrist provides them with the correct medicine according to their correct diagnoses.  
• The psychologist helps them deal with their current thought processes and emotions.  
• The psychiatric nurses promote and maintain their mental health in a therapeutic environment.  
• The occupational therapist teaches them about recreation.  
• Group therapy helps them to learn from themselves in a safe environment.  
• Group therapy assist them in acquiring more effective socialising skills.  
• A structured programme provides structure in their disrupted lives.  
• Specialists in some of their other medical conditions are in contact with their psychiatrist before prescribing certain treatments. |
| 2.2 Adult females experience various essential needs that have to be met in order for them to recover:  
• Information on their illness and the medication they are taking. | |
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<th>THEMES</th>
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<td></td>
<td>To have control of their own lives again.</td>
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<td></td>
<td>To be understood.</td>
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<td></td>
<td>To have emotional support from loved ones, family and colleagues.</td>
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<td></td>
<td>Acceptance by society without being stigmatised.</td>
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<td>Stable finances to afford treatment.</td>
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3. Adult females experience the development of intrapersonal skills and, therefore, realise their responsibility for their own lives

3.1 Adult females experience that they start taking responsibility for their own lives by:

- Continuing with their medication without changing or stopping it by themselves.
- Taking their medication on a regular basis and at the same time every day.
- Having regular follow-ups with the psychiatrist and therapist.
- Starting to socialise with other people.
- Being willing to be admitted to a psychiatric facility when necessary.
- Doing research on mental health issues and attending lectures and group sessions to learn still more.

3.2 Adult females experience factors which contribute to staying motivated on their recovery journey:

- Their love for their partners and/or children.
- The hope and trust that one day they will be able to cope better with life and even enjoy life.
- Their own remarkable experience of their own journey from the black hole to life again.
- Viewing themselves as worthy of living a full life.
3.7 DISCUSSION OF THE RESULTS

The interpretation and discussion of the findings were based on the major themes and categories that are schematically summarised in Table 3.1.

3.7.1 The central theme

Adult females with depression experience their treatment initially as trial and error and eventually as lifesaving. The therapeutic relationship between the adult females and the members of the multi-disciplinary team is a pertinent component in promoting their mental health. They develop intrapersonal skills and, therefore, realise their responsibility for their own lives.

The major themes and categories will be described and discussed with quotes from the interviews conducted in this study, along with the literature review. These quotes relate to the discussed content in the categories.

3.7.2 Theme 1: Adult females with depression experience their treatment initially as trial and error and eventually as life-saving

The participants shared the stories of their initial contact with psychiatric medicine and treatment. They described their experience of their treatment as a journey that was initially a process of trial and error, until they eventually found the right treatment that was life-saving for them and ensured a better quality of life.

The categories discussed below support theme one.

3.7.2.1 Adult females experience the start of their treatment in the care of general practitioners but comply poorly with prescribed treatment

The majority of the participants described how they started their treatment under the care of a general practitioner but due to a lack of certain elements described below, they complied poorly with their treatment.
a) A thorough evaluation of their holistic health needs

Most of the participants started their treatment in the care of a general practitioner. It seems as if the profoundly important principle of holistic care was absent. They felt that there was a need for both medication and therapy, and that they were each unique. As a result they felt the same medication prescribed for one, would not necessarily work for another. Most of them also had co-morbid conditions that had impacted on their depression, and they felt a need for holistic care for all their conditions. The following direct quotations are an illustration of this:

“…it’s a complicated illness this…it has a medical…it has a biological or physiological element…” (Participant: 8).

“…now on Venlor…also Trepiline…also Arcoxia…also Pur-bloka, Enap…it works together so that my whole system…with all the illnesses…you must see which medicine will work with the medicine that the one doesn't actually disrupt…then you fall off balance.” (Participant: 6).

“But you can do nothing in isolation. You can’t just to an ECT, you can’t just do oral, you can’t just do clinical. You have to combination of the…of the whole.” (Participant: 5).

“I went to a specialist psychiatrist who does medication and some of the therapy and the whole tooti…the whole...wide sort of skill set…and what a difference!…I just think it’s imperative to have therapy with medication. I don’t think one without the other works I think they work in conjunction.” (Participant: 7).

“…that it’s not a one-size-fits-all.” (Participant: 8).

Many patients in primary care-seeking treatment with a general practitioner present with a mixture of physical, psychological and social problems. Holistic assessments are required that include underlying social and physical problems (Maxwell & Pratt,
There is a higher prevalence of depression and co-morbid conditions, and increasing evidence that depression is associated with other chronic conditions such as coronary artery disease, hypertension, diabetes, HIV, multiple sclerosis, cancer and patients on dialysis (Kramer, Beaudin & Thrush, 2005:301-302). According to McPherson and Armstrong (2012:1153-1154), general practitioners are unable to view depression in a holistic sense because of the foundation of their traditional medical training and they question the concept of depression being an illness. They are also found to have limited knowledge in the disease model of depression.

b) A team approach by health care providers

Participants experienced a need for a team approach that included the multi-disciplinary team (that is, psychiatric nurses, psychologists, occupational therapists and psychiatrists) and not just medication being prescribed, but also therapy in combination that was important.

One participant said:

“It’s not all about medicines and being selected that does its role too… I would have been in a worse state without my clinical psychologist.” (Participant: 2).

Another said:

“But you can’t just have medication without therapy.” (Participant: 7).

Another participant added:

“…ek is geheel en al ‘n ander mens met medikasie, terapie en met die manier wat hulle my leer om dinge te doen.” (I am totally a different person with the medication, therapy and the way that they teach me how to do things). (Participant: 3).
General practitioners only refer 5-10% of psychiatric pathologies to mental health professionals (Montero-Marin, Carrasco, Roca, Serrano-Blanco, Gili, Mayoral, Luciano, Lopez-del-Hoyo, Olivan, Collazo, Araya, Baños, Botella & García-Campayo, 2013:2). Antidepressants are often prescribed by primary care providers without the consideration of inclusion of treatment by a mental health specialist. The management of depression not only includes the primary care practitioner bus also management by a psychiatrist, psychologist and other mental health professionals (Kramer, et al. 2005:297-298).

c) A psycho-educational programme which educates them on their illness

Initially, some of the participants experienced a lack of insight relating to their illness and treatment. Participants indicated that they had a need to gain insight and receive education on depression and their treatment for better understanding. The following comments support this view:

“…but I didn’t really understand. So I didn’t really want to do it.”
(Participant: 5).

“Let somebody…who is an expert on this…let them teach me.”
(Participant: 8).

“…and he used to give me a prescription for sleeping pills and antidepressants, ‘take these pills’ – no explanation what it does”
(Participant: 5).

Effective patient education programmes are necessary to ensure treatment adherence and to improve patients’ understanding and knowledge of the disease to prevent relapse (Mei-Feng, Moyle, Hsiu-Ju, Mei & Mei-Chi, 2008:668). Patient education addresses patients’ concerns and improves their understanding of their condition (Maxwell & Pratt, 2008:189). Psychoeducation treatment programmes teach patients about their mental illness, its treatment and management, and this helps them cope better and prevents relapse (Uys & Middleton, 2010:54, 258).
d) **Regular follow-ups**

Regular follow-ups with their doctor are required, and this included the time that was made available by the doctor for consultation, or that the doctor spends with them. This is supported by the statements:

“Beforehand it’s just been every three months, half-an-hour appointments.” (Participant: 8).

“I didn’t go for another year…” (Participant: 8).

“…and they give you medication, ‘Take these pills in the morning, every morning and take these at night’ and off you go. I’ll see you in six months’ Whoopi-do. What did that do?” (Participant: 5).

“…now this doctor comes along and it’s as if she doesn’t care. I mean, she doesn’t care…a doctor that just sees a patient within three minutes.” (Participant: 6).

Management of depression in primary care includes long-term follow-up of adherence and outcomes. Infrequent follow-ups lead to less favourable outcomes (Brody, 2003:21). Frequent doctor-patient contact is necessary and improves patient compliance with treatment (Ruoff, 2005:851). Methods that assist the clients’ adherence to treatment include the development of a strong therapeutic alliance with the client, and keeping in close contact, which includes regular follow-up (Mohr, 2003:253).

e) **Clinical observations by psychiatric nurses to evaluate and intervene in their adaptation to medicine**

When they are admitted to the hospital, there is usually a significant change in their medication regime. In the facility, the psychiatric nurses are there to monitor any changes and to provide support with difficulties experienced due to changes in medication. This is evident by the following narratives:
“...I think it’s the right meds...in the beginning its heavy and she is increasing it. Being in here we are doing it, because we can, because the staff is around to look after me.” (Participant: 4).

“Here I’ve been administered my medicines on the time that the nurses have records of and when and what and who and whatever.” (Participant: 2).

“...dan gaan ek na hulle toe, na die susters toe, dan gee hulle vir my daardie Stresam.” (...then I go to the sisters, then they give my that Stresam). (Participant: 3).

The evaluation by the psychiatric nurse of a client’s medication regimen includes reviewing the medication efficacy in improving functioning, and discussions with the client about their subjective perception of response (Mohr, 2003:255). Continual nursing assessment of the individuals’ treatment and care leads to more successful treatment (Kneisl & Trigoboff, 2014:195).

f) Limited knowledge of the side-effects of their medicine

The participants verbalised that they were not provided with the necessary information and knowledge on their medication and possible side-effects that could occur.

One participant said:

“...but I’m not sure about the side-effect of being on it for a long time...I don’t know what the long-term effect on it is.” (Participant: 2).

Another said:

“...Paxil, which I’ve only found recently, give you...tinnitus...Had I known that – I had such issues with my ears last year and dizziness and car sickness and motion sickness and it was from the Paxil, which
I didn’t know…Also not knowing things like if I get sick and I have to take cortisone, to be aware of that because it’s a depressant. I didn’t know that.” (Participant: 7).

Another participant added:

“…and he used to give me a prescription for sleeping pills and anti-depressants, ‘take these pills’ – no explanation what it does.” (Participant: 5).

Factors that lead to non-adherence of treatment in depression includes a lack of adequate communication between physicians and patients about the side effects of treatment (Bron, O’Neill & Fogel, 2006:285). Appropriate education for patients starting antidepressants should include discussions on potential side effects (Dunlop, Scheinber & Dunlop, 2013:178). Doctors communicating and discussing adverse treatment effects with their patients, improve treatment compliance (Ruoff, 2005:851).

3.7.2.2 Adult females experience the following factors which lead to their being admitted to a psychiatric facility and starting treatment with a psychiatrist

The participants expressed that they experienced specific factors that precipitated them being admitted to a private psychiatric hospital. This hospitalisation initiates the start of treatment under the care of a psychiatrist.

a) A suicidal attempt

A suicide attempt is the catalyst that leads to the participants being admitted to a psychiatric hospital for medication and treatment review. It is depicted by the following quotations from participants:

“Ek het ‘n oordosis pille gedrink. En die paramedici en ambulanse was binne ek sou sé, ek dink 10 minute by my huis.” (I overdosed on pills
and the paramedics and ambulances were within 10 minutes, I would say, at my house). (Participant: 3).

“I did try to commit suicide, seven times…then they admitted me.” (Participant: 6).

“Jy pleeg selfmoord omdat jy jouself die lyding will spaar. Ek was nou baie naby aan dit, maar ek dink dis hoekom ek hier is.” (You commit suicide to save yourself the suffering. I was very close to it now, but I think that is why I am here). (Participant: 9).

“I attempted suicide last year, my boyfriend found me, rushed me to XXX…So…if I never attempted suicide I don’t think I’d come in for treatment” (Participant: 1).

The South African Stress and Health Study (SASH) concluded that the group of South Africans that are at higher risk for suicide were younger, less educated and females (Joe, Stein, Seedat, Herman & Williams, 2008:454). Adult females are three times more likely to attempt suicide and are more likely to have received psychiatric treatment (Kornstein & Clayton, 2002:152). Management of a suicide attempt includes hospitalisation, especially if the patient has a strong suicidal intent (Baumann, 2008:137).

b) They cannot continue endlessly pretending they are doing fine while having depression

Even though they were not coping in their everyday lives, they wore masks and pretended to the outside world that they were fine and coping while they were actually not fine. The participants realised that they could not continue pretending and wearing these masks endlessly. It is apparent from the following participant quotations:
“…you’ve actually got a smile on your face on the outside, but on the inside you’re broken…I mean inside everything is tearing apart. You don’t feel well, but you’re saying to everyone ‘no I’m fine, there’s nothing wrong with me’”. (Participant: 6).

“It was just almost masking some of the you know covering up some of the symptoms rather than actually making you feel happier.” (Participant: 8).

“…as much as I walk around here and at home and at work, and I smile…They never understood, but my whole life I’ve worn a mask. It’s part of my everyday life.” (Participant: 1).

“I hit big time depression. I just feel dead inside…and that is not me…That’s my façade. I don’t show people what’s on the inside.” (Participant: 4).

According to Epstein, Duberstein, Feldman, Rochlen, Bell, Kravitz, Cipri, Becker, Bamonti and Paterniti (2010:957), many patients with depression reported delays in seeking care by normalising their symptoms as “everyday life problems that many other people are going through” and only seek treatment once their symptoms got severe. Holm and Severinsson (2014:131,137) reported that in multiple studies of narratives of patients with depression, a mask of normalcy is worn and they hide their depression from other people.

c) The loss of a job

Depression have led to many of the participants not being able to go to work or not being able to do the work that were required of them, and this have led to some participants losing their jobs. Some of the participants also felt that they could not disclose their illness to their employees or colleagues as this jeopardised the relationships they had with their peers and how they were viewed. The following quotations are an illustration of this:
“…at work…I made the mistake of telling them that I have depression. I should never have disclosed that to them.” (Participant: 5).

“…you get fired; so many people have lost their jobs.” (Participant: 7).

“I will be less inclined to do what I need to do because I can’t focus on what I need to do and I’ll get into more S.H.I.T. at work.” (Participant: 1).

“There’s been days where I haven’t gone to work because of it.” (Participant: 1).

Depression can have a major and detrimental effect on people’s personal, social and occupational functioning (Ziebland, Locock, Fitzpartick, Stokes, Robert, O’Flynn, Bennert, Ryan, Thomas & Martin, 2014:595). Depression can be a consequence of unemployment where it has an effect on obtaining and retaining jobs and could be seen as a barrier to employment (Keyes & Goodman, 2006:310-311, 315). Stigma towards those with psychiatric disorders are prevalent in the work environment, resulting in clients not being hired for jobs based on their depression (Mohr, 2003:302).

d) Concerned loved ones who step in and take them to a psychiatrist or to hospital

Participants’ loved ones are the first to realise or to note that help is needed and they are the ones who take the participants to their psychiatrist and/or hospital to get the necessary help and treatment. The following comments support this:

“…I didn’t want to come, but my family were really worried and they got in touch with the psychiatrist…everybody that I love is concerned…” (Participant: 8).
“…ek bly by my ma hulle...en toe kom hulle agter,…ek drink nie my pille nie, en toe het hulle my laat opneem.” (...I stay with my mom and them...and then they realised....I don't drink my tablets and then they got me admitted). (Participant: 9).

“I will phone my boyfriend and he'll be there in a heartbeat...He’ll drop whatever it is that he’s doing. He’s walked out of executive meeting before to come and save me.” (Participant: 1).

“…Then they actually admitted me...but luckily at that stage...and the support of my brother and my dad...” (Participant: 6).

Patients may have difficulty in recognising symptoms of depression in themselves although others can notice a change in mood (Alderson, Foy, Glidewell & House, 2014:7). Relatives act as risk assessors. They do risk assessment and prediction in terms of relapse and risk of the patient to himself and others (Pilgrim, 2014:96). People with social support are more likely to seek treatment compared to people lacking social support (Anderson, Schierenbeck, Strumpher, Krantz, Topper, Backman, Ricks & Van Rooyen, 2013:444).

e) They realise they need long-term treatment when they see the harm their neglecting of their illness caused their loved ones

The participants came to the realisation that their depression is a chronic disease that will require treatment for the rest of their lives. They realised that when they did not get the necessary or proper treatment, their neglect of their condition had a negative impact on their relationships with their loved ones and some verbalised having hurt their loved ones as a result. This is evident from the following narratives:

“You are hurting your family more than what you’re helping them. One day a day is gonna come they’re gonna turn around and tell you to fuck off...We’ve helped you more than what we could, the rest is up to you, so screw you.” (Participant: 1).
“And I feel for my child. And I actually moved her to my ex-husband. And she has been staying with him for a while because it’s not fair on her. She should see Mommy happy and not a Mommy that can just about drag her bum out of bed and shower and get dressed to go work in the morning. It’s not, it’s not fair on the people around you.” (Participant: 4).

“…but when you start forgetting your children’s names and for a week on end you can’t remember their names…then it becomes a problem…that’s the worst part of my depression…my intelligence has kind of gone…down the tubes.” (Participant: 5).

“…I didn’t realise that I’m going to have to do this my whole life.” (Participant: 8).

Major Depressive Disorder is often a chronic and recurring disorder and thus affect individuals for many years, and often decades, of their lives (Accortt, Freeman & Allen, 2008:1583). Treatment adherence is the voluntary participation of individuals in therapy and taking medications in an effort to manage the effects of their illness. The ultimate benefit of adherence encompasses long-term benefit for patients (Vuchovich, 2010:78).

3.7.3 Theme 2: Adult females experience the therapeutic relationship with the members of the multidisciplinary team as a pertinent component in promoting their mental health

The participants reported that the curative and healing relationship with the members of the multidisciplinary team that includes the psychiatric nurses, psychologists, occupational therapists and psychiatrists, brings about beneficial and positive change that facilitates the restoration of their mental health and improved quality of life.

The categories discussed below support theme two.
3.7.3.1 Adult females experience the multidisciplinary team with the different professional disciplines to work in collaboration with one another

The participants experience interrelation of the multidisciplinary team, which includes the psychiatric nurses, psychologists, occupational therapists and the psychiatrists and their common goal in working as a team in aiding their recovery.

a) The psychiatrist provides them with the correct medicine according to their correct diagnoses

Psychiatrists first do proper evaluations and the necessary investigations before making the correct psychiatric diagnoses, and this leads to getting correct medication, specifically relating to the diagnoses. The participants felt that a psychiatrist has the expertise to make the diagnoses and often the incorrect diagnoses and/or treatment were given/made by their GP’s. This led to them not getting proper care or treatment. It is apparent from the following participant statements:

“…I think it’s extremely difficult to correctly diagnose this and that’s why it’s so terrible for a GP to do this…if you have these conditions, you need a proper evaluation and a proper experienced psychiatrist to give you the right stuff.” (Participant: 8).

“Dr. XXX doesn’t prescribe anything before doing a blood test on you…she does an analysis of your…blood result before she decides what to do…what treatment to put you on, And if she sees something doesn’t work, she’ll change it…I’ve been on the right combination…which seems to be working fine now.” (Participant: 5).

“…I’m just relieved they’ve finally got a proper diagnosis” (Participant: 7).

Psychiatrists view that effective and proper treatment starts only once the correct and accurate diagnosis is made (Dunlop, et al. 2013:176). Appropriate levels of
treatment is only achieved when a correct diagnosis is made by those qualified to do so. Knowledge of symptoms and signs, and the correct analysis are crucial in the establishment of diagnosis and the choice of treatment. Most psychiatric diagnoses are missed by non-specialists/psychiatrists (Madlala & Sokudela, 2014:175).

b) The psychologist helps them deal with their current thought processes and emotions

The psychologist focuses more on the participants’ past and assist with their thought processes and also how to deal with their emotions. They feel that the emotions are then more manageable, and they are more in control of their emotions. This is supported by the following quotes:

“…met die behandeling het ek nou begin leer om met my emosies te deal op papier.” (…with the treatment I have now learnt how to deal with my emotions on paper). (Participant: 3).

“So hy help my oor my verlede te kom, in ‘n groot sin, met sy terapie sessies…Nou met die behandeling wat ek deurgaan is dit net asof ‘n mens, dit voel of berg van jou skouers afkom…my emosies is nie meer oral of rondom my nie.” (So he helps deal with my past, in a big way, with his therapy sessions…Now with the treatment I am going through it is as if, it feels if a mountain is lifted from you shoulders…my emotions is not all over the place anymore). (Participant: 3).

“…refer you to a psychologist, to maybe see if you have to change your habits.” (Participant: 5).

“…they psychologist, he talks to you. He helps you actually the way you think about a situation. He guides you.” (Participant: 6).

There are several forms of psychotherapy that is effective in the treatment of depression (Dunlop, et al. 2013:178). Psychological therapies, such as cognitive behavioural therapy, has a strong evidence base for treating depression, and there is
a number of psychological interventions that have shown benefits in the treatment of depression (Lund, Schneider, Davies, Nyatsanza, Honikman, Bhana, Bass, Bolton, Dewey, Joska, Kagee, Myer, Petersen & Prince, 2014:8, 16). Referral to psychological therapies is associated with better treatment compliance with antidepressants (De Lusignan, Chan, Tejerina, Parry, Dent-Brown & Kendrick, 2013:383).

c) The psychiatric nurses promote and maintain their mental health in a therapeutic environment

Psychiatric nurses are empathetic and seen as warm and compassionate. Their care aid in the participants’ mental health and the positive and supportive climate set in the therapeutic environment of the private hospital setting. It is portrayed in the following quotes:

“The nurses here are fantastic…They are a special bunch of nurses…They are educated to understand what’s wrong. So they have an amazing way of dealing with us and…always greeting you and making you feel like you are someone. Because I think by the time you get in here you really don’t feel like you are someone. You feel worthless, and whatever. So they, they are awesome!” (Participant: 4).

“But tablets on its own, you’re not going to get better. It doesn’t work. You need a support system. You need other people like psychiatric nurse, nurses in a facility like this.” (Participant: 5).

“…the nurses are very friendly, helpful…They assist you if they see you need help or another patient…they’re not even criticising.” (Participant: 6).

“…almal hier is baie nice…al die verpleegpersoneel en dit help…” (…everyone here is very nice…all the nursing staff and it helps). (Participant: 3).
The environment or milieu in a psychiatric hospital can be used as part of therapy (Eby & Brown, 2005:124). Psychiatric nurses provide an important role in the therapeutic environment and this affects the treatment outcome of patients (Kneisl & Trigoboff, 2014:563).

d) **The occupational therapist teaches them about recreation**

The occupational therapist equips them with the tools and knowledge of recreational activities for everyday life that they can do as part of promoting their mental health.

One participant said:

“...*hulle gee jou tools wat jy genuine kan gebruik, met ‘n alledaagse omgewing, ‘n alledaagse budget en ‘n alledaagse lewe.*” …*they provide you with tools that you can genuinely use, with an everyday environment, a everyday budget and an everyday life.* (Participant: 9).

Another said:

“You actually do occupational therapy as well....that makes you think in a different way. That you didn’t even think about it...It’s the whole teaching and learning and helping and even the thinking is different. It makes you different.” (Participant: 6).

Another participant added:

“...*put that input when you’re at home, don’t just stay in the house...let’s go for a movie or let’s go have a milkshake at Milky lane.*” (Participant: 6).

Recreational therapy plans and guides recreational activities to provide interpersonal experiences and socialisation (Kneisl & Trigoboff, 2009:23). Recreational therapy
provided by occupational therapists assist patients in finding leisure interests that help them learn to balance work and play (Keltner, Schwecke & Bostrom, 2007:308).

e) Group therapy helps them to learn from themselves in a safe environment

The group therapy sessions provide a safe and non-judgemental space for the participants where they can learn from one another. They also feel that they are not alone and that there are others who can provide support. It is apparent from the following participant statements:

“…all the classes and the groups, they help and we support actually one another…we do in separate groups but…we all went actually through the same thing…but it’s been very useful and helpful and a lot of information is given…you actually look in another perspective that you never thought about.” (Participant: 6).

“You know then you will actually have something to say…these groups they actually understand one another and they can talk to one another.” (Participant: 6).

“…met die groepsessie wat ons gehad het…verstaan ek dit beter.” (…with the group session we had….I understand it better). (Participant: 3).

Supportive groups provide opportunities for education and support to the group members (Frisch & Frisch, 2002:715). Members in a group share their challenges and what they have learned from their experiences and the benefits of being able to help one another cope (Eby & Brown, 2005:164). Group therapy creates a climate of warmth, empathy and a trusting atmosphere and allow patients to share parts of themselves and still feel accepted. It provides opportunities to learn from others through sharing different ways of coping (Baumann, 2008:618).
f) Group therapy assists them in acquiring more effective socialising skills

Prior to hospitalisation, some of the participants find it difficult to socialise with other people. When they have been admitted to the hospital and have attended the group therapy sessions, they acquire skills and the confidence to interact and socialise with other people again. This is supported by the following extracts:

“…people actually didn’t socialise or communicate like one another as here…since…the classes…you get the socialisation of the people. You know you discuss things in the groups.” (Participant: 6).

And:

“You now actually get to know people, even talk more with people, like you must learn now how to socialise.” (Participant: 6).

Also:

“…you keep yourself in a corner, you don’t want to see people, you don’t want to go out…you don’t want to talk to people…But here they actually like kind of break that eggshell and then you start popping out.” (Participant: 6).

Structured group activities allow individuals to interact with each other (Eby & Brown, 2005:167). Therapy that focus on the improvement and development of social skills help individuals develop more supportive friendships. Social skills assist individuals to establish and maintain social support that help them through stressful times and prevents them from developing a depressive episode (Nasser & Overholser, 2005:130). The therapeutic factors of group therapy include the development of socialising skills (Yalom, 2005:1, 16-17).
g) **A structured programme provides structure in their disrupted lives**

The psychiatric hospital had a specific two or three-week programme for participants to attend, with a definite routine and everything at particular times. This structured programme provided structure that was also essential to continuing with in their everyday lives. The following comments support this view:

“…we have a climate meeting here on a Tuesday…” (Participant: 5).

“…a health institute like this or you know a mental institute…they can show you the correct path…you get the two weeks or the three weeks…” (Participant: 6).

“It needs to go with keeping a proper bedtime routine…” (Participant: 8).

The physical environment of the hospital, rules and daily schedules of treatment activities provide structure that is an important component of psychiatric treatment (Keltner, et al. 2007:290). The hospital’s therapeutic milieu and scheduled activities, provides structure for patients’ daily living (Eby & Brown, 2005:124). According to Maxwell and Pratt (2008:189), systematic reviews have demonstrated the positive effects of structured care for patients with depression.

h) **Specialists in some of their other medical conditions are in contact with their psychiatrist before prescribing certain treatments**

Some of the participants shared their experience of having more than one diagnosed chronic condition and thus had to see other medical specialists besides their psychiatrist. Their psychiatrist and other specialists communicated with each other regarding prescribing and providing certain treatments and sharing the participants’ medical history and treatment regimes. This is supported by the quotations that follow:
“…there is a lot of problems with my cognitive uh memory…I have been referred to a neurologist”. (Participant: 5).

“…you can’t get one doctor that actually specialises in all…I am now with rheumatologist…I’m also now with dr. XXX (psychiatrist) and also with dr. YYY (psychiatrist). They will actually contact one another and also get some more information even whether it’s blood results that needs to be sent through…they would talk to one another if they want information or know more about something.” (Participant: 6).

“En toe laas jaar April moes hulle ‘n shunt vir my insit, en na die shunt het die neuroloog toe ook gesê hulle mag glad nie meer ECT’s doen nie…” (And then last year April that had to insert a shunt for me, and after the shunt the neurologist also said that they may not do anymore ECT’s). (Participant: 9).

According to Maxwell and Pratt (2008:191), living with a chronic physical illness is likely to have an impact on an individual’s mental health and having a mental health problem may increase the risk of developing physical illnesses, such as coronary artery disease and diabetes. Winchester, Watkins, Brahm, Harrison and Miller (2013:798) report that a collaborative, multidisciplinary approach is needed. There should be planned collaborative care between medical physicians and mental health clinicians in the care and treatment of patients.

3.7.3.2 Adult females experience various essential needs that have to be met in order for them to recover

Participants experience that there are various basic needs that first need to be met in order to aid their recovery from depression.

a) Information on their illness and the medication they are taking

One factor that stood out in the majority of the participants’ experiences was the essential need for information, and to be provided with knowledge of the medication
that was prescribed to them. This included the use, what it was supposed to do, and possible side- or adverse effects that could be expected. This is evident by the following narratives:

“So it’s much better now that I’m with someone who really knows their stuff, as opposed to other psychiatrists that I’ve been to that haven’t been as informative, with the meds as I would have preferred them.” (Participant: 7).

“…I wish I’d get more information about you…like the ECT’s, yes I got a flyer…that was three or four pages stapled to each other about the ECT’s and we got to watch a video about what ECT’s were.” (Participant: 1).

“Lexamil, I dunno what the hell that does…but if I knew what medication did what…it would be nice.” (Participant: 7).

One of the barriers patients experience is the lack of knowledge about their symptoms of depression or the treatment of depression (Epstein, et al. 2010:954). To a large extent successful treatment depends on the patients’ understanding of their treatment (Fontaine, 2003:206). Patients understanding their mental illness helps them and their families to cope better, and this also improves their quality of life and prevents relapse (Keltner, et al. 2007:309-310).

b) **To have control of their own lives again**

Loss of control is initially experienced in many spheres of their lives. They have a need to regain control over their lives again and their treatment plays a significant role in gaining back this control. This is supported by the following extracts:

“…I like to know where I am, I like to know what I’m doing, when I’m doing it, how I have to do it…I don’t know if I’m Arthur or Martha, I don’t know if I am coming or if I am going.” (Participant: 1).
And:

“…vandat ek op hierdie medikasie is, dit help my net! Dit help my om beter met my emosies te deal, in beheer the kry.” (…since if have been on the medication, it just helps me! It helps me deal better with my emotions, to gain control). (Participant: 3).

Also:

“…when I'm on my meds...I'm stable...if it's under control…” (Participant: 7).

Adult females with depression experience a sense of loss of control of both their inner feelings and outer surrounding events, and a general sense of losing control over their lives. Social theories of depression support that depression is associated with a feeling of loss of control over the social environment that is depressogenic (Gask, Aseem, Waquas & Waheed, 2011:53). According to O’Brien and Fullagar (2008:10), adult females with depression viewed recovery from depression in relation to a recovered self; of being in control of depression.

c) To be understood

The participants felt the need for them and their condition to be understood by others. They experienced a general lack of understanding and sympathy towards people with mental illnesses in society. The following quotations are an illustration of this:

“…the people on the outside who don’t understand.” (Participant: 8).

“…not a lot of people do understand it. Society – I think if one more person tells me just, like, to ‘just build a bridge’ and ‘snap out of it!’ Because that is society. They are, they are ignorant. And they don’t want to learn about it.” (Participant: 4).
“…they’ve got no sympathy for me being here. They don’t understand...they don’t understand that it’s actually a mental illness.” (Participant: 5).

Patients view the importance of being understood as part of the management of depression (Alderson, et al. 2014:6). Holm and Severinsson (2014:137) reported that narratives of people with depression included the need to be understood by others.

d) To have emotional support from loved ones, family and colleagues

Emotional support from their loved ones and family, as well as their work colleagues prevent them from relapsing. They do experience isolation, or the world to be a lonely place if they do not receive this support. This is expressed by the following:

“…my hele familie is simpatiek teenoor my…en vir my te sê wanneer hulle die tekens sien date ek besig is om the relapse.” (…my whole family is sympathetic towards me…and to tell me when they see the signs that I am busy to relapse). (Participant: 3).

“It’s very, very sad when people don’t have empathy for your condition and it’s a very lonely world when you can’t share it and especially, with people that are close to you.” (Participant: 5).

“So my brother, he supports me…he knows I must take that medication...for myself you know to actually stay alive and keep coping.” (Participant: 6).

Support from peer groups, social networks and family is a critical component in treatment (Keltner, et al. 2007:542). Low levels of emotional support from family, friends and the outside network of individuals, have been associated with the onset of a depressive episode, whereas a supportive family, friends and a supportive outside network can aid in recovery from depression. This emotional support includes trust, concern, empathy and love (Nasser & Overholser, 2005:125-126,
Families can make a big difference as supporters in the treatment for the psychiatric client (Eby & Brown, 2005:134).

e) **Acceptance by society without being stigmatised**

Adult females with depression do experience the burden of the stigma attached to their illness and mental health. They receive little or no acceptance by others in society when it comes to them taking or receiving treatment for their depression. It is still perceived as not being a real illness, and just a sort of figment of the imagination that could quickly be altered. The following comments supported this view:

“…so many people are on medication for depression. Not everybody knows and they don’t all tell that they’re on it…I think they’re shy to admit it because it’s the stigmatism that goes with it…” (Participant: 5).

“I think the biggest stigma attached to depression, is people go ‘just get over it’ or ‘just get on with it’ or ‘pull yourself together’. If it was that easy, there would be no need for this place!” (Participant: 7).

“And I had gone off it due to pressure from my mom and from XXX. Doing the ‘but look at you! You are fine! You don’t need to take that shit. Stop!'” (Participant: 4).

“Depressie het ‘n geweldige stigma…Depressie het is nie goed nie. Mense dink jy’s mal en jy’s dom en jy’s onverantwoordelik en hulle kan nie op jou staat maak nie, en dit is totaal en al nie waar nie.” (Depression have a huge stigma. To have depression is not good. People think you are crazy and stupid and that you are irresponsible en that they cannot rely on you, and that is totally not true). (Participant: 9).

The stigma associated with mental health is a significant field and individuals generally feel that there are negative attitudes held by the public. Stigma may be in different forms and include enacted/experienced stigma, anticipated/perceived
stigma and internalised/self-stigma. Enacted stigma is the acts of discrimination by others because an individual has a mental health disorder (Sorsdahl, Kakuma, Wilson & Stein, 2012:55, 59). According to Turner, Sharp, Folkes and Chew-Graham (2008:452, 454), adult females feel that there is a stigma attached to taking anti-depressants and that others would view them as mentally unstable and unable to cope on their own.

f) Stable finances to afford treatment

Even though they all had medical aids and access to private health care, the participants experienced that the costs involved in getting their medication, hospitalisation, and their consults with psychiatrist, were stressful. They still found it difficult to get their medication approved on chronic benefits and had to make co-payments. The medical aid industry made it difficult for them to get full cover and have only certain conditions and treatments that are covered under chronic benefits. Not all medical aid plans cover the chronic conditions and it is often only the top and more expensive plans that do make provision for this. This is supported by the participant quotations:

“The hardest thing that’s been about the medication in all honesty, has been fighting with medical aid and getting it on chronic…So the money involved every month just to get my meds on chronic, has been an issue and an issue and an issue.” (Participant: 7).

“…my brother, he supports me…if I don’t have money to actually pay the excess after this, ag, you know the medical aid, he would pay for it.” (Participant: 6).

“I’ve had a few psychiatrists who’s lied on the form so that I can get the pills that I need on chronic and the money cost involved and then paying R 3 000 a month for medical aid…That’s the biggest concern and the most stressful part of this whole process is how do you afford it.” (Participant: 7).
Many individuals are concerned with the affordability and costs of medical care in South Africa and this is seen a barrier in treatment (Anderson, et al. 2013:446). The cost of treatment remains a factor and doctors often have to change from one class of medication to another class that is more cost effective and less expensive and often older drug classes are used (McPherson & Armstrong, 2012:1155). According to Kramer, et al. (2005:302), doctors have also been facing problems with reimbursement if depression is coded on claims, and this influences private health cover.

3.7.4 Theme 3: Adult females experience the development of intrapersonal skills and, therefore, realise their responsibility for their own lives

The participants bravely took up the responsibility of taking charge of their lives again for their own sake as well as for their loved ones. Development of crucial intrapersonal skills is not an easy road for them, but they do hope and trust in the process. They felt positive about receiving treatment and even if they do not feel joyful every day, their new perspective and sense of responsibility carry them forward in this process of recovery.

The categories discussed below support theme three.

3.7.4.1 Adult females experience that they start taking responsibility for their own lives

The participants expressed how they started taking responsibility for their own lives again through the following methods:

a) Continuing with their medication without changing or stopping it by themselves

Initially, the participants told their stories of not taking their medication as prescribed, and stopping it prematurely. They then realised that it was irresponsible and a mistake, and that they would need to take their treatment long-term without stopping it before consulting with their doctors. The participants said the following:
“I was very irresponsible with my medication. So sometimes I would take it and other times I wouldn’t…I would take it and then not take it.” (Participant: 7).

“…Initially…I fought the fact that ‘ah, I’m only going to be on it for a couple of months and then I’ll go off it’. I’ve now made peace over the years that I’m one of those people, I just don’t want to have serotonin in my brain and I’m going to take it like a diabetic takes insulin.” (Participant: 7).

“…I just know that I need to have faith, that it will work out and I wanna continue the treatment.” (Participant: 1).

“…maar ek het my medikasie gelos, en ek moes dit nooit gelos het nie.” (...but I have stopped my medication and I should have never stopped it). (Participant: 3).

“Ek’s bly ek is terug op medikasie en ek sal nooit weer die fout maak om myself af the haal nie.” (I am glad I am back on the medication and I will never make the mistake again to take myself myself off). (Participant: 9).

Fifty to eighty percent of patients with prescribed antidepressants either discontinue their medication prematurely or take it too inconsistently to attain any clinical benefit from it (Aikens, et al. 2008:23). According to Pilgrim (2014:120), patients that comply with their treatment lead successful treatment outcomes, rehabilitation and recovery.

b) Taking their medication on a regular basis and at the same time very day

It is important not only to take the medication continuously and on a regular basis but also at the same time daily. Some experienced a huge difference and improvement
in their condition when they took their medication at the right time. They emphasised this by the following verbalisations:

“I’ve got to drink it three times a day.” (Participant: 6).

“…the timing of when they take their meds, the changing of the timings, you can actually physically see an improvement.” (Participant: 7).

“…take your medication…It needs to go with taking at the right time.” (Participant: 8).

“That works a lot easier that taking some in the morning and some at night.” (Participant: 1).

Compliance with treatment includes following recommendations of health care providers, which include recommendations regarding the dosage and timing of medication (Demyttenaere, 1997:29). Patients taking antidepressants should be informed and educated about the necessity of consistent daily dosing of medication (Dunlop, et al. 2013:178).

c) Having regular follow-ups with the psychiatrist and therapist

Regular follow-up appointments with the psychiatrist to monitor their medication, as well as regular therapy sessions with the psychologist, are an essential part of therapy and their recovery. It is apparent from the following comments:

“I had seen Dr. XXX (psychiatrist) for a while…and I started seeing a psychologist…” (Participant: 4).

“You can’t just take your pills and think you’ll get better, so it requires effort…commitment to, and buying into the process of it’s not only that part, that’s the psychiatrist’s problem to fix out what medication you
need…but you can’t just have that, you need to work on your thought processes". (Participant: 8).

“I kept going and going and going for treatment…and I saw a clinical psychologist…” (Participant: 2).

“Maak ‘n afspraak by jou psigieter. Gaan sien jou psigieter. Gaan sien jou sielkundige.” (Make and appointment with your psychiatrist. Go see your psychiatrist. Go see your psychologists). (Participant: 3).

Effective depression care and follow-up includes a collaborative multidisciplinary model of care (Winchester, et al. 2013:798). Regular re-evaluation of therapy is needed to achieve a remission state of depression (Dunlop, et al. 2013:178).

d) Starting to socialise with other people

Participants initially found it difficult to socialise with others and had to force this process of socialising, but after a while this got easier and they felt more relaxed in the company of others. One participant said:

“En ek het aan die begin toe ek hier gekom het, die eerste twee dae het ek met niemand gepraat nie…ek moet my self forseer om met die mense te sosialiseer.” (And in the beginning when I got here, the first two days I did not speak with anyone…I have to force myself to socialise with people). (Participant: 3).

Another said:

“I don’t communicate with a lot of people because I never socialised actually…that’s one of the things that I must also now start to put in my life so that I can get my friends again…” (Participant: 6).
Another participant added:

“You know actually get to know people; even talk more to people, like you must learn now how to socialise…” (Participant: 6).

Social dysfunction and social isolation are common in mental illness and thus, social skills training is necessary in treatment and rehabilitation (Uys & Middleton, 2010:255). The client has the responsibility for the creation of their world and they are therefore responsible for its change. They must develop a new sense of their interpersonal involvement in the world (Yalom, 2005:183).

e) Being willing to be admitted to a psychiatric facility when necessary

Part of their process of taking responsibility for their illness and treatment is the readiness and willingness to be admitted to the psychiatric facility. If they are not willing and have been forced by others to be admitted, they do not engage fully in the treatment process and this evidently affects the outcome of recovery negatively. The following quotations are an illustration of this:

“…ek kyk na van die mense en dan besef ek hulle is nie reg om hier te wees nie, en as jy nie reg is om hier te wees nie, dan defeat jy die object.” (...I look at the people and then I realise they are not ready to be here and if you not ready to be here, then you the defeat the object). (Participant: 9).

“…some people here that I’ve seen over the last few days that just don’t want to engage, they don’t want to be here…” (Participant: 8).

“…jy moet positief ingaan en jy moet dit wil doen. Dit help nie hulle laai jou by die hek af, want dan gaan hulle niks regkry met jou nie. Hulle gaan die pille kry om te werk en jy gaan miskien lewe, maar jy gaan nie ‘n kwaliteit lewe het nie.” (...you have to go in positively and you need to want to do it. It won’t help them dropping you off at the gate, because then they won’t get anything right with you. They will get the
pills to work and you might live, but you won’t have a life of quality).
(Participant: 9).

A client who voluntarily seeks treatment is more compliant with their therapy and
treatment than those who are pressured into treatment. External motivation is related
to a positive treatment outcome only when internal motivation is also present
(Keltner, et al. 2007:525). Until patients who are hospitalised acquire hope and the
motivation to engage in treatment, no progress will be made (Yalom, 2005:109). To
be aware of the problem, to identify sources of help and being willing to seek and
disclose the problem, is promotive factors for seeking and getting help (Anderson, et
al. 2013:446).

f) Doing research on mental health issues and attending lectures and
group sessions to learn still more

The participants educate themselves and gain knowledge relating to their treatment
and condition by doing research, attending lectures and group sessions. They
empower themselves by constantly asking questions to gain knowledge. It is
apparent from the following views:

“You go to SADAG.org and go and research bipolar…and I need to
learn about it…and go find out what’s wrong with me.” (Participant: 4).

“…I will ask always ‘what are these tablets, what will they do?’
Because I’ve learnt now – find out what are you taking? Why are you
taking it?” (Participant: 5).

“…take responsibility for it and learn, learn, learn, educate yourself…”
(Participant: 7).

“...I want to learn and get better.” (Participant: 8).

Patients who take responsibility for their own learning confirm the efficacy by
recognition of the importance of learning and this leads to positive attitudinal and
behavioural changes. The desire to learn about depression information and adaptation can reduce depression symptoms, achieve optimal life satisfaction and improve psychological well-being (Mei-Feng, et al. 2008:669).

3.7.4.2 Adult females experience factors which contribute to staying motivated on their recovery journey

The participants experienced factors that aided and contributed to them staying motivated on their road to recovery and remission from depression.

a) Their love for their partners and/or children

Love for their partners and especially the participants’ children, give them a drive to do everything they could to recover and become better mothers and spouses again for their loved ones. This is evident from the following narratives:

“...I need to do anything and everything I can in my power to give my son the best mother I can, and I'm not gonna stop until I do.” (Participant: 1).

“...and the I realised how much my boyfriend and my son is hurting because of what I'm doing, and it opened up my eyes a lot more and made me more willing to try whatever it is that I needed to try.” (Participant: 1).

“I'm here to make a decision or basically a decision for my son and our future together and how I must go about it and give me the courage to go forward and that is what's helping me.” (Participant: 6).

Predictors in recovering from depression include feelings of warmth and compassion from partners relating to their condition (McLeod, Kessler & Landis, 1992:281). According to Foland-Ross, Cooney, Joorman, Henry and Gotlib (2014: 819), the recalling of happy memories aid to recover negative mood states in depression.
b) The hope and trust that one day they will be able to cope better with life and even enjoy life

Hope that there will be a better future and that they will get better and again cope better with life, motivates them. There is that hope that their thoughts will not be consumed with their depression and negative thoughts any longer, but that they will be able to enjoy the simple and everyday things in life again. The following comments supported this:

“I’m really, really hoping that Dr. XXX is right and things will get better...I will rather have little hope than no hope...even if it’s the slightest chance that it could work even if it’s 0,001%. I’d rather hang on to the 0,001% than try and focus on the other 99.999% that says it’s not going to work...” (Participant: 1).

“...enjoying the kitty lying in the sun, or you know appreciating the birds...but things that should make you happy, are making you happy and you appreciate food and you appreciate the small things that you know...not to the point where I want to be dead but I’m always wanting to be happier.” (Participant: 8).

“Ek vertel my self die hele tyd: ’moenie worry nie. Dit gaan fine wees. Jy gaan ’n fantastiese toekoms hê. Jy gaan vinnig op jou bene wees. Dit lyk nou vir jou erg, maar dit is nie so erg as wat jy dink nie”. (I tell myself the whole time: ‘Yo are going to be okay, you must not worry. It is going to be fine. You are going to have a fantastic future. You are soon going to be on your feet). (Participant: 3).

Patients with depression believed that despite the chronicity of their depression they have a positive view that treatment offers hope for recovery (Alderson, et al. 2014:7). Psychiatric rehabilitation and recovery is the strengthening of self-care and improvement in the quality of an individual’s life and this includes emphasis on the recovery of hope and development of functional competencies (Mohr, 2003:148). Installation of hope helps the client to maintain faith in the therapeutic modality. The
client is optimistic and believes that he or she will get better (Yalom, 2005:4-6; Mohr, 2003:161).

c) Their own remarkable experience of their own journey from the black hole to life again

The participants shared their story of a journey that started negatively, where they saw themselves in a black hole but then it turned into a positive journey where they could see light and become their old selves again. The following quotations are an illustration of this:

“...like a hole...and everything that went with that nightmare” (Participant: 2).

“...this is going to give me my chutzpah back...Because I've been sick for a long enough...” (Participant: 4).

“You get into this black hole that you can’t see how you're ever going to get out...” (Participant: 5).

“...because before you know it you’ll you know just be in a bad hole again...” (Participant: 8).

Patients with depression explained and described their feelings as “always dark” (Epstein, et al. 2010:957). When the experience of depression is described, the terms of being in a black hole is associated with depression (Waite & Killian, 2007:165; Winters, 2000:38). Also, adult females with depression describe symptoms of depression that include feelings of hopelessness and unhappiness which often is described as being in a dark/black hole (Highet, Stevenson, Purtell & Coo, 2014:182,183).
d) Viewing themselves as worthy of living a full life

Participants view themselves as worthy of living a full life again, where their mood is improved and they have a positive outlook for the future, and not the grim life they had before. One participant said:

“…I look forward to improved mood and improved everything.”

(Participant: 5).

And:

“I just want to get better. That's, for me, and this point in my life is the most important thing is to get better. And I think I've got a second lease on life, so I’m excited about that…” (Participant: 5)

Another participant added:

“Jy gaan okay wees. Jy gaan ’n fantastiese lewe vorentoe hê” (You are going to be okay. You are going to have a fantastic future).

(Participant: 3).

Low self-esteem and self-worth are associated with depressive symptoms with the occurrence of a depressive episode (Keyes & Goodman, 2006:149). According to O’Brien and Fullagar (2008:10), adult females with depression viewed recovery as a return to a previous sense of self and full functioning capacity.

3.8 SUMMARY

The results of the research findings of the in-depth phenomenological interviews with adult females of their lived experiences with depression and their treatment, were discussed. Figure 3.1 (see below) is an illustration of the themes of the lived experiences of their treatment by adult females with depression. A literature review was also included to validate the findings of this research study. In Chapter Four the
guidelines, conclusions, evaluation of the study and recommendations will be discussed.

FIGURE 3.1: A summary of the themes of the lived of experiences of their treatment by adult females with depression

Theme 1: Adult females with depression experience their treatment initially as trial and error and eventually as life saving.

Theme 2: Adult females experience the therapeutic relationship with the members of the multidisciplinary team as a pertinent component in promoting their mental health.

Theme 3: Adult females experience the development of intrapersonal skills and therefore realise their responsibility for their own lives.
CHAPTER 4
DISCUSSION OF GUIDELINES, CONCLUSIONS, EVALUATION OF THE STUDY AND RECOMMENDATIONS

“Never regret. If it's good, it's wonderful. If it’s bad, it's experience.”
— Victoria Holt

4.1 INTRODUCTION

The lived experiences of their treatment by adult females with depression was explored in Chapter Three. In this chapter the guidelines to assist the psychiatric nurse to facilitate adult females regarding compliance with their treatment is discussed.

Also, the evaluation of this study, and the limitations and recommendations will be presented as part of this chapter.

4.2 DISCUSSION OF GUIDELINES

Based on the results discussed in Chapter Three, guidelines to assist the psychiatric nurse to facilitate adult females regarding compliance with their treatment are presented in Table 4.1.

**TABLE 4.1: Guidelines to assist the psychiatric nurse to facilitate adult females with depression regarding compliance with their treatment to promote mental health**

<table>
<thead>
<tr>
<th>Themes and categories as per results in Chapter Three</th>
<th>Guidelines to assist the psychiatric nurse to facilitate adult females with depression regarding compliance with their treatment to promote mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td>THEME 1: Adult females with depression experience their treatment initially as trial and error and eventually as life-saving</td>
<td>GUIDELINE 1: Provide holistic treatment care that facilitates treatment compliance that leads to life-saving promotion of mental health</td>
</tr>
<tr>
<td>Themes and categories as per results in Chapter Three</td>
<td>Guidelines to assist the psychiatric nurse to facilitate adult females with depression regarding compliance with their treatment to promote mental health</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>1.1 Adult females experience the start of their treatment in the care of general practitioners but comply poorly with prescribed treatment because of a lack of the following:</strong></td>
<td></td>
</tr>
<tr>
<td>a) A thorough evaluation of their holistic health needs.</td>
<td>a) Conduct a thorough evaluation of holistic health needs.</td>
</tr>
<tr>
<td>b) A team approach by health care providers.</td>
<td>b) Collaborate a team approach by health care providers.</td>
</tr>
<tr>
<td>c) A psycho-educational programme which educates them on their illness.</td>
<td>c) Provide a psycho-educational programme that educates them on their illness.</td>
</tr>
<tr>
<td>d) Regular follow-ups.</td>
<td>d) Ensure regular follow-ups.</td>
</tr>
<tr>
<td>e) Clinical observations by psychiatric nurses to evaluate and intervene in their adaptation to medicine.</td>
<td>e) Conduct clinical observations relating to evaluate and intervene in their adaptation to medicine.</td>
</tr>
<tr>
<td>f) Limited knowledge of the side-effects of their medicine.</td>
<td>f) Provide them with knowledge of the side-effects of their medicine.</td>
</tr>
</tbody>
</table>

**THEME 2: Adult females experience the therapeutic relationship with the members of the multidisciplinary team as a pertinent component in promoting their mental health**

<table>
<thead>
<tr>
<th>GUIDELINE 2: Foster a therapeutic relationship between the multidisciplinary team to facilitate treatment compliance that promotes mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Adult females experience the multi-disciplinary team with the different professional disciplines to work in</td>
</tr>
</tbody>
</table>
### Themes and categories as per results in Chapter Three

<table>
<thead>
<tr>
<th></th>
<th>Guidelines to assist the psychiatric nurse to facilitate adult females with depression regarding compliance with their treatment to promote mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>collaboration with one another:</strong></td>
</tr>
<tr>
<td>a)</td>
<td>a) Facilitate the correct diagnoses and medicine through consultation with a psychiatrist.</td>
</tr>
<tr>
<td>b)</td>
<td>b) Deal with current thought processes and emotions through psychotherapy sessions with a psychologist.</td>
</tr>
<tr>
<td>c)</td>
<td>c) Facilitate a therapeutic environment.</td>
</tr>
<tr>
<td>d)</td>
<td>d) Teach them about recreation through occupational therapy sessions.</td>
</tr>
<tr>
<td>e)</td>
<td>e) Facilitate learning from one another in a safe environment in group therapy sessions.</td>
</tr>
<tr>
<td>f)</td>
<td>f) Facilitate the acquiring of more effective socialising skills in group therapy sessions.</td>
</tr>
<tr>
<td>g)</td>
<td>g) Provide a structured programme.</td>
</tr>
<tr>
<td>h)</td>
<td>h) Collaborate contact between specialists in their other medical condition and psychiatrists.</td>
</tr>
</tbody>
</table>

**a)** The psychiatrist provides them with the correct medicine according to their correct diagnoses.

**b)** The psychologist helps them deal with their current thought processes and emotions.

**c)** The psychiatric nurses promote and maintain their mental health in a therapeutic environment.

**d)** The occupational therapist teaches them about recreation.

**e)** Group therapy helps them to learn from themselves in a safe environment.

**f)** Group therapy assist them in acquiring more effective socialising skills.

**g)** A structured programme provides structure in their disrupted lives.

**h)** Specialists in some of their other medical conditions are in contact with their psychiatrist before prescribing certain treatments.
### Themes and categories as per results in Chapter Three

<table>
<thead>
<tr>
<th><strong>2.2 Adult females experience various essential needs that have to be met in order for them to recover:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Information on their illness and the medication they are taking.</td>
</tr>
<tr>
<td>b) To have control of their own lives again.</td>
</tr>
<tr>
<td>c) To be understood.</td>
</tr>
<tr>
<td>d) To have emotional support from loved ones, family and colleagues.</td>
</tr>
<tr>
<td>e) Acceptance by society without being stigmatised.</td>
</tr>
<tr>
<td>f) Stable finances to afford treatment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Guidelines to assist the psychiatric nurse to facilitate adult females with depression regarding compliance with their treatment to promote mental health</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.2 Ensure that the following essential needs are met:</strong></td>
</tr>
<tr>
<td>a) Provide information on their illness and the medication they are taking.</td>
</tr>
<tr>
<td>b) Facilitate the gaining back of control of their own lives.</td>
</tr>
<tr>
<td>c) Validate their feelings and needs to be understood.</td>
</tr>
<tr>
<td>d) Promote emotional support from loved ones, family and colleagues.</td>
</tr>
<tr>
<td>e) Promote acceptance and the de-stigmatisation of depression and treatment.</td>
</tr>
<tr>
<td>f) Identify resources that can assist with maintaining stable finances to afford treatment.</td>
</tr>
</tbody>
</table>

### THEME 3: Adult females experience the development of intrapersonal skills and therefore realise their responsibility for their own lives

<table>
<thead>
<tr>
<th><strong>3.1 Adult females experience that they start taking responsibility for their own lives by:</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>GUIDELINE 3: Develop intrapersonal skills to take responsibility to be compliant with their treatment and facilitate promotion of mental health</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3.1 Develop a sense of responsibility to be compliant with their treatment that includes:</strong></td>
</tr>
<tr>
<td>Themes and categories as per results in Chapter Three</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>a) Continuing with their medication without changing or stopping it by themselves.</td>
</tr>
<tr>
<td>b) Taking their medication on a regular basis and at the same time every day.</td>
</tr>
<tr>
<td>c) Having regular follow-ups with the psychiatrist and therapist.</td>
</tr>
<tr>
<td>d) Starting to socialise with other people.</td>
</tr>
<tr>
<td>e) Being willing to be admitted to a psychiatric facility when necessary.</td>
</tr>
<tr>
<td>f) Doing research on mental health issues and attending lectures and group sessions to learn still more.</td>
</tr>
</tbody>
</table>

3.2 Adult females experience factors which contribute to staying motivated on their recovery journey:

| a) Their love for their partners and/or children. | a) The use of their love for their partners and/or children. |
| b) The hope and trust that one day they will be able to cope better with life and even enjoy life. | b) The installation of hope to cope better with and enjoy life. |
| c) Their own remarkable experience of their own journey from the black hole to live again. | c) The use of their own recovery journey catharsis process. |
4.2.1 Guideline 1: Provide holistic treatment care that facilitates treatment compliance that leads to life-saving promotion of mental health

The Theory of Health Promotion in Nursing supports holistic treatment, where the patient comprises of mind, body and soul and is in constant interaction with his/her internal and external environment and this influence his/her mental health (Department of Nursing Science: University of Johannesburg, 2010:4-8). Guidelines are formulated in this study to assist the psychiatric nurse to facilitate and aid treatment compliance that leads to promotion of mental health.

Holistic treatment care that facilitates treatment compliance that leads to the life-saving promotion of mental health includes the following actions:

a) Conduct a thorough evaluation of holistic health needs.
b) Collaborate a team approach by health care providers.
c) Provide a psycho-educational programme that educates them on their illness.
d) Ensure regular follow-ups.
e) Conduct clinical observations relating to evaluation and intervention in their adaptation to medicine.
f) Provide them with knowledge of the side-effects of their medicine.

Compliance with treatment includes the combined effects of pharmacological, psychological and social interventions (Sin & Gamble, 2003:152). The need for holistic care in relation to patient medication-taking is important in the bio-psycho-social approach to defining adherence that is synonymous with compliance (Lehane & McCarthy, 2009:29).
4.2.2 Guideline 2: Foster a therapeutic relationship between the multidisciplinary team to facilitate treatment compliance that promotes mental health

A therapeutic relationship between the multidisciplinary team is fostered by a collaborative approach and by ensuring that essential needs are met to facilitate treatment compliance that promotes mental health. The psychiatric nurse plays an integral part in fostering the therapeutic relationship between the multidisciplinary team and also act as an advocate for their patients by ensuring this relationship.

4.2.2.1 Foster a collaborative approach between the multidisciplinary team

A collaborative approach between the multidisciplinary team is facilitated and promoted by the following actions:

a) Facilitate the correct diagnoses and medicine through consultation with a psychiatrist.

b) Deal with current thought processes and emotions through psychotherapy sessions with a psychologist.

c) Facilitate a therapeutic environment.

d) Teach them about recreation through occupational therapy sessions.

e) Facilitate learning from one another in a safe environment in group therapy sessions.

f) Facilitate the acquiring of more effective socialising skills in group therapy sessions.

g) Provide a structured programme.

h) Collaborate contact between specialists of their other medical conditions and psychiatrists.

Adherence to treatment is influenced by strong therapeutic relationships and shared decision-making or informed collaborative choice which is the two-way process between the patient and the healthcare practitioners (DiMatteo, et al. 2012:79). According to Sin and Gamble (2003:152), optimal medication management includes collaboration between the psychiatric nurse, the patient’s psychiatrist and the whole
multi-professional team. Katon (2012:550) also concludes that collaborative care and a team approach increased depression treatment adherence.

4.2.2.2 Ensure that the following essential needs are met

The psychiatric nurse ensures that the patient’s essential needs are met by the following actions:

a) Provide information on their illness and the medication they are taking.
b) Facilitate the gaining back of control of their own lives.
c) Validate their feelings and needs to be understood.
d) Promote emotional support from loved ones, family and colleagues.
e) Promote acceptance and the de-stigmatisation of depression and treatment.
f) Identify resources that can assist with maintaining stable finances to afford treatment.

Adherence interventions to treatment should be designed to the needs of the patient in order to achieve optimum results (Sebate, 2003:30). According to DiMatteo, et al. (2012:78), in order to promote treatment adherence the individual patient needs must be targeted.

4.2.3 Guideline 3: Develop intrapersonal skills to take responsibility to be compliant with their treatment and facilitate promotion of mental health

By the development of intrapersonal skills to take responsibility for compliance and the promotion of motivational factors for treatment, compliance is facilitated for the promotion of mental health.

4.2.3.1 Develop a sense of responsibility to be compliant with their treatment

The psychiatric nurse facilitates the development of the participant’s sense of responsibility to be compliant with their treatment. This sense of responsibility includes:
a) Continuation of their medication without stopping it by themselves.

b) Taking their medication on a regular basis and at the same time every day.

c) Having regular follow-ups with their psychiatrist and therapist.

d) Encouraging socialisation with other people.

e) The willingness to be admitted to a psychiatric facility when necessary.

f) Fostering of a learning curiosity to know more about mental health issues.

Patients taking responsibility for their actions and life roles, and taking personal responsibility for health and wellness, is associated with progress in recovery. The acquiring of skills in intrapersonal dimensions includes patients taking personal responsibility and shifting their identity in the direction of a functional citizen, leads to progress of recovery (Noordsy, Torrey, Mueser, Mead, O’Keefe & Fox, 2002:319, 320).

4.2.3.2 Promote motivational factors to stay compliant with treatment and to recover

The psychiatric nurse uses the following motivational factors to promote participants to stay compliant with their treatment and to aid recovery:

a) The use of their love for their partners and/or children.

b) The installation of hope to cope better with and enjoy life.

c) The use of their own recovery journey catharsis process.

d) The installation of self-worth to live a full life.

Patients with depression feel in order to recover from depression they have to draw strength from inner-resources by having a positive attitude and by being self-motivated (Holm & Severinsson, 2014:136). Health professionals should identify the important people in a patient’s life and examine their roles in the patient’s beliefs and attitudes as part of the patient’s motivation to treatment compliance. One of the reasons for nonadherence includes a lack of motivation to carry out treatment recommendations (DiMatteo, et al. 2012:79, 82). According to Lehane and McCarthy (2009:29), one of the definitions of ‘adherence to treatment’ incorporates the patients’ habits, health beliefs and motivation.
4.2.4 Summary of the guidelines

A summary of the guidelines formulated to assist the psychiatric nurse to facilitate adult females regarding compliance with their treatment is illustrated in Figure 4.1.

![Diagram of guidelines]

**FIGURE 4.1:** Schematic representation of guidelines to assist the psychiatric nurse to facilitate adult females with depression regarding compliance with their treatment to promote mental health

4.3 CONCLUSIONS AND EVALUATION OF THE STUDY

The researcher, having worked in both the public and private sector as a psychiatric professional nurse, noted across all sectors that depression is still very much treated as a biomedical illness where treatment is given to aid recovery. It appeared to the researcher that this treatment given is rather “something that is done to” the patients with minimal patient input. When the researcher asked questions such as “why do adult females not comply with their treatment?” the majority of the answers were still
related to the biomedical model and answers included “side-effects of medication”. The researcher’s interest was triggered in the attitudes, beliefs and cognitive processes or thought processes of why adult females do not comply with their treatment or terminate treatment prematurely. In view of the above information, the researcher asked the following questions:

- What are the lived experiences of adult females with depression regarding their treatment?

- What can be done by the psychiatric nurse to facilitate adult females regarding compliance with their treatment?

The purpose of the study was to explore and describe the lived experiences of adult females with depression regarding their treatment, and to formulate guidelines to assist the psychiatric nurse to facilitate adult females regarding compliance with their treatment. The central question: “How do you experience your treatment?” was asked during the interviews.

The objectives of the study was reached because its aim was to explore and describe the lived experiences of adult females with depression regarding their treatment and to formulate guidelines to assist the psychiatric nurse to facilitate adult females regarding compliance with their treatment.

One of the challenges faced by the researcher was that she did not work at the facility where data were collected and did not know or have a prior rapport with the participants. She attributed this as contributing to the participants appearing to have closed body postures at first, but as the interviews progressed and a rapport was built, the participants appeared more relaxed. The reflective notes of the researcher considered if other data or themes would have surfaced if the researcher had a better rapport with the participants or if it might have worked in her favor that she was not known. Other challenges included the environment where the interviews were conducted. The only relatively suitable rooms that could be used to conduct the interviews were close to the entrance and nurses station and even though a “do not disturb: session in progress” sign was placed on the rooms during the interviews, on
some of the occasions patients in the ward or hospital personnel still ignored this sign and interrupted the interviews.

4.4 RECOMMENDATIONS

Recommendations to the psychiatric nursing practice, nursing education and nursing research to assist psychiatric nurses to facilitate adult females with depression to be compliant with their treatment, are discussed below.

4.4.1 Psychiatric nursing practice

Mental health is a dynamic interactive process in the patient’s internal and external environment. The patterns of interaction of patients with their internal and external environment determine their health status as an integral part of health. Psychiatric nursing is an interactive process where the psychiatric nurse as a sensitive and therapeutic professional mobilises resources in order to facilitate the promotion of health (Department of Nursing Science: University of Johannesburg, 2010:4, 5). The psychiatric nurse can contribute towards the promotion of mental health in female patients with depression by facilitating them to be compliant with their treatment and by assisting in their recovery/remission of their mental illness, so they are able to function as a whole person in all spheres.

4.4.2 Psychiatric nursing education

Mental health education provides individuals, groups and families with knowledge and insight into all aspects of promotion of mental health and prevention of mental illness (Uys & Middleton, 2010:251). Nursing curriculums for student nurses and in-service training programmes for qualified psychiatric students should include educating them with the necessary skills to equip the psychiatric patients with knowledge and insight relating to compliance with their treatment to facilitate promotion of mental health.
4.4.3 Psychiatric nursing research

The combination of individual expertise with the best clinical based evidence from systematic research provides evidence-based practice, which leads to best nursing practices and clinical excellence (Kneisl & Trigoboff, 2009:47, 48, 53).

Further nursing research is recommended in:

- A more diverse and larger population: repeating this study with males, in different life spans, adolescents, and the elderly, in a more diverse ethnic population and in the public sector across different economic income groups.

- The evaluation of the implementation of the guidelines proposed in this study and the impact or improvement it has on patient treatment compliance.

- The development of a model/theory for psychiatric nursing to facilitate treatment compliance for the promotion of mental health.

4.5 SUMMARY

Through a qualitative, explanatory, descriptive and contextual research design this study explored and described the lived experiences of adult females with depression regarding their treatment. Through phenomenological interviews and the incorporation of field notes, the findings were analysed and documented. Guidelines were formulated based on the experiences of the participants in this research study. A conclusion was drawn and an evaluation of the study and recommendations were provided.
LIST OF REFERENCES


APPENDIX 1

ETHICAL APPROVAL FROM THE UNIVERSITY OF JOHANNESBURG, FACULTY OF HEALTH SCIENCES, ACADEMIC ETHICS COMMITTEE
FACULTY OF HEALTH SCIENCES

ACADEMIC ETHICS COMMITTEE

AEC39-01-2013

18 July 2013

TO WHOM IT MAY CONCERN:

STUDENT:                RADEMEYER, A
STUDENT NUMBER:         909901013

TITLE OF RESEARCH PROJECT:     The lived experiences of their treatment by adult females with depression

DEPARTMENT OR PROGRAMME:      MCUR: Psychiatric Mental Health Nursing

SUPERVISOR:                  Prof M Poggenpoel
CC-SUPERVISOR:               Prof CPH Myburgh
Dr A Temane

The Faculty Academic Ethics Committee has scrutinised your research proposal and confirm that it complies with the approved ethical standards of the Faculty of Health Sciences, University of Johannesburg.

The AEC would like to extend their best wishes to you with your postgraduate studies.

Yours sincerely,

Prof M Poggenpoel
Chair : Faculty of Health Sciences AEC
APPENDIX 2

REQUEST TO CONDUCT RESEARCH (TO THE ETHICS COMMITTEE AND HOSPITAL)
UNIVERSITY OF JOHANNESBURG
FACULTY OF HEALTH SCIENCES
DEPARTMENT OF NURSING SCIENCE

15 April 2013

Riverfield Lodge
Ethics committee

REQUEST TO CONDUCT RESEARCH

Dear Sir/Madam,

My name is Anita Rademeyer. I am a professional nurse and I am currently registered with the University of Johannesburg for the Masters Degree in Advanced Psychiatric Nursing. In order to fulfill all the requirements for a master’s degree, I am currently doing a research project to which I would like to invite prospective participants to participate.

The title of the research projects is "THE LIVED EXPERIENCES OF THEIR TREATMENT BY ADULT FEMALES WITH DEPRESSION" the study will be done under supervision and guidance of Professor M Poggenpoel, Professor C P H Myburgh and Doctor A Temane, at the University of Johannesburg. I hereby request authorisation to conduct this research within the jurisdiction of your hospital. I will also request permission from the participants who will be willing to participate in the research study.

The objectives of this study are:

- To explore and describe the lived experience of adult females with depression regarding their treatment.
- To formulate guidelines to assist the psychiatric nurse to facilitate adult females regarding compliance to their treatment.

After obtaining permission from prospective participants’ phenomenological interviews will be conducted for 45-60 minutes. Only one open-ended question will be asked during the interview: "How do you experience your treatment?" This interview will be audio-taped with participants’ permission and transcribed verbatim for verification of findings by an independent psychiatric nurse specialist and my supervisors. The audiotapes will be kept under lock and key, only my supervisors and I will have access to the audiotapes. The audio-tapes will be destroyed two year after publication of the research. Participants will not be identified in any way in this study.
The participants may withdraw at any time without any effect on their treatment. The benefit for participants in this study is that they will be able to verbalise freely on their experience of their treatment. Based on an understanding of their experience of their treatment guidelines will be described for psychiatric nurses to facilitate their compliance regarding treatment. Feedback will be provided on the results of this study on your request. My contact number is 083 642 4994.

Sincerely,

Marie Poggenpoel
Anta Rademeyer
M Cur Psychiatric Nursing student

Marie Poggenpoel
Marie Poggenpoel, RN, PhD
Professor: Nursing Science

Chris Myburgh, BSc Hon, MComm, DEd, HED
Professor: Psychology of Education

Annie Temane, RN, PhD
Lecturer: Nursing Science

UNIVERSITY
OF
JOHANNESBURG
APPENDIX 3

REQUEST TO CONDUCT RESEARCH (TO THE PROSPECTIVE PARTICIPANTS)
REQUEST TO CONDUCT RESEARCH

Dear Prospective Participant,

My name is Anita Rademeyer. I am a professional nurse and I am currently registered with the University of Johannesburg for the Masters Degree in Advanced Psychiatric Nursing. In order to fulfill all the requirements for a master's degree, I am currently doing a research project to which I would like to invite you to participate.

The title of the research project is "THE LIVED EXPERIENCES OF THEIR TREATMENT BY ADULT FEMALES WITH DEPRESSION" the study will be done under supervision and guidance of Professor M Poggenpoel, Professor C P H Myburgh and Doctor A Temane, at the University of Johannesburg.

The objectives of this study are:

- To explore and describe the lived experience of adult females with depression regarding their treatment.
- To formulate guidelines to assist psychiatric nurses to facilitate adult female compliance to their treatment.

After obtaining permission from you I will conduct a phenomenological interview that will take 45-60 minutes, whereby you will describe your experience regarding your treatment. Only one open-ended question will be asked during the interview: "How do you experience your treatment?" This interview will be audio-taped with your permission and transcribed verbatim for verification of findings by an independent psychiatric nurse specialist and my supervisors. The audio-tapes will be kept under lock and key in a cupboard in my office and only my supervisors and I will have access to the audio-tapes. The audio-tapes will be destroyed two years after publication of the research. You will not be identified in any way as a participant in this study.

You may withdraw at any time without any effect on your treatment. The benefit for you in this study is that you will be able to verbalise freely on your experience regarding your treatment. Feedback will be provided on the results of this study on your request. If you have any questions regarding this study feel free to contact me. My contact number is 083 642 4984.
Sincerely,

Marie Poggenpoel
Anta Redemeyer
M Cur Psychiatric Nursing student

Marie Poggenpoel
Marie Poggenpoel, RN, PhD
Professor: Nursing Science

Chris Myburgh, BSc Hon, MComm, DEd, HED
Professor: Psychology of Education

Annie Temane, RN, PhD
Lecturer: Nursing Science
CONSENT FORM TO PARTICIPATE IN THE RESEARCH STUDY

I (Name in full) ________________________________ have read
and understand the consent in the request letter to participate in the research study on
"THE LIVED EXPERIENCES OF THEIR TREATMENT BY ADULT FEMALES WITH
DEPRESSION"

Further on I confirm that I give permission freely, knowing that the information given to the researcher will be treated confidentially and anonymously even though the University of Johannesburg will make the final result of the research study public to the academic world.

I also know that at any time I may withdraw my consent participation without any penalty. I have had enough time to ask questions and the answers have been satisfactory. I also consent for audio taping of the interview, and analyzing of narrative sketches.

PARTICIPANT:

Name: __________________________ Signature: __________________________ Date: __________

RESEARCHER:

Name: __________________________ Signature: __________________________ Date: __________
APPENDIX 5

PARTICIPANT CONSENT FORM FOR PERMISSION TO AUDIOTAPE THE INTERVIEW
CONSENT FORM FOR PERMISSION TO AUDIO-TAPE THE INTERVIEW

I (Name in full) ____________________________________________ have read
and understand the consent in the request letter to participate in the research study on
"THE LIVED EXPERIENCES OF THEIR TREATMENT BY ADULT FEMALES WITH
DEPRESSION"

I confirm that I understand that I have to opportunity to ask questions regarding the
research study and information regarding audio-taping, privacy, confidentiality and
anonymity.

I hereby give my permission that the interview with me can be audio-taped.

PARTICIPANT:

Name: __________________________________ Signature:_____________ Date:___________

RESEARCHER:

Name: __________________________________ Signature:_____________ Date:___________
APPENDIX 6

HOSPITAL PERMISSION LETTER TO CONDUCT THE RESEARCH
Anita Human
University of Johannesburg
Faculty of Health Sciences - Department of Nursing Science

Request for permission to conduct research

Dear Anita,

Many thanks for the request for permission to conduct research at our XXXXXXXXXX on the topic: "THE LIVED EXPERIENCES OF THEIR TREATMENT BY ADULT FEMALES WITH DEPRESSION". XXXXXXXXXX supports the development of this field through evidence-based research and we welcome research projects conducted in our units.

I hereby grant permission to you to access our mental health unit for the purpose of conducting your research under the following conditions:

- Patient confidentiality is to be respected at all times, and therefore:
  - All appropriate patients will be presented with a letter from the researcher requesting the patients' participation in the research project.
  - Data on patients have to be managed in accordance with the Protection of Private Information Act.
- You may only access information and use it for the purposes outlined in your research proposal.
- Patients have the right to refuse participation in the study.
- No official XXXXXXXXXX documentation or photocopies may leave the premises of XXXXXXXXXX and patient files must remain on the property at all times.
- XXXXXXXXXX may not be identified by name.
- Access to patient documentation must be controlled and supervised.
- Access to the unit is dependent upon permission by the relevant managers to limit disruption to the unit's routine and patients' rehabilitation programmes.

I wish you success with your research, and look forward to the results. We would appreciate a copy of your research upon completion.

Sincerely,

[Signature]

Hospital Manager
APPENDIX 7

EXTRACT FROM A SELECTED INTERVIEW
**R:** How do you experience your treatment?

**P:** *Uhm* it’s okay. It’s just the ECTs that I struggle with a bit. *Uhm* I’m .. I’m not too keen on having my brain shocked, but if it’s what’s gonna get me to, where I need to go [chuckles] then I’ll do it. The only problem is I lose a lot of memories. [the respondent had an open posture, no arms or legs crossed. She was turned towards the researcher. She was making eye contact and appears comfortable].

**R:** Hm-hm?

**P:** And I don’t know how to regain them back. That’s my only problem that I have with my .. with the ECTs. With my medication I’m fine and we moved all my medication to during the evening because it used to be take some in the morning and then some at night, but it ended up having dry mouth; I wasn’t able to concentrate properly.

You know there was a lot of downscales down - I dunno how to say it, *uhm* a lot of negatives [chuckles] to taking my medication in the morning and then Doctor XXX changed my medication to taking it during the evening and that works. That works a lot easier than taking some in the morning and some at night.

**R:** Tell me more about this negatives that you experience?

**P:** *Uhm* .. I feel very disorientated. I lose a lot a lot of time and I don’t where it went. *Uhm* and like I said, I have dry mouth and I will experience a loss of appetite because of it and *uhm* I will be less inclined to do what I need to do because I can’t focus on what I need to do and I’ll get into more SH1T at work [chuckles] because I don’t do what I have to do because I can't concentrate with the medication that I’m on.

And I can't remember the name, I think it was the Lexamil that I was taking in the morning and then my other medication I was taking at night. And it’s, it’s ... *uhm* I don’t know how to say – it’s
extremely disorientating and it’s, it’s frustrating because I’m .. I am not the kind of person – I don’t like to know where I’m not.

Ja, I like to know where I am, I like to know what I’m doing when I’m doing it, how I have to do it and when I took it in the morning I wasn’t able to do that. And then the only way is that I would remember what I had to do was if I had to write it down beforehand and then – I’d, I’d sit with my boyfriend and tell him ‘Okay, baby, this is what I need to do’ and then he’ll say ‘okay, well, what about this do you need to do’ and I’ll explain it to him and then when the time comes for me to do it, I’ll read [slight sigh] ‘ah, this is what I need to do, how the hell am I supposed to do it’ and then I’ll call David and then David will say ‘okay, baby, you said that you need to do this and when you do this, this is how you need to do it’ and then I’ll remember ‘okay, this is what I need to do’.

R: Hm.

P: So ... the rest of the time .. I dunno. [laughs]

R: What do you mean you don’t know?

P: Uhm .. I don’t know if I’m Arthur or Martha, I don’t know if I am coming or if I am going .. like where I stand, what I should do, what I shouldn’t do. I’d, like I would start supper and I burn supper because I just lose track of time. I wouldn’t even remember that I had supper on the ta.., on the stove until my cousin will shout or my boyfriend or my son would shout ‘supper is burning!’ [laughs]

So, uhm, ja, I needed a lot of help when I was taking my medication during the morning as well, as opposed to everything at night. I think it’s, it’s .......... maybe because it, it gives time for it to settle in my body ....