

**Card games and containment: Forensic psychiatric patients'
experiences of a student-led initiative**

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Abstract

Despite South African forensic psychiatric institutions operating well over capacity, the urgent need for rehabilitation guidelines is neglected through lack of research in this area. This is further compounded by the constrained financial and professional resources available to the sector. The Fort England Hospital Buddy Programme (FEHBP) is a voluntary social and activity-based initiative involving 2 hourly visits between students and male forensic psychiatric patient volunteers. Through the use of Interpretative Phenomenological Analysis (Smith, 1996), the participants' experience of the programme was further contextualised within their lives pre and post admission. While further exploration through research is required, it appeared that within institutional confines the FEHBP acted in a substitutionary and surrogacy capacity, as a space for the development of social competence. While participants appeared to experience a sense of protectiveness from the programme, the limitations and restrictions are acknowledged as an increased number and variety of social network links would be required for a more sustainable sense of subjective wellbeing to develop. The FEHBP demonstrates the use of non-professional (community involved) interventions within a forensic psychiatric context.

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Table of Contents

Abstract	i
Acknowledgements.....	ii
Introduction.....	1
Literature Review.....	3
Methodology	25
Analysis of themes.....	47
Discussion.....	68
References.....	83
Appendix 1 – Informed Consent.....	90
Appendix 2 – Interview schedule (first set of interviews, 2012).....	91
Appendix 2 ctd.....	92

Introduction

While it has been contended that deinstitutionalisation (and along with it the shift in view point from ‘patients’ to ‘consumers of mental health services’) has increased the impetus for patient-centred research (Bowers, 2005), this viewpoint has, for the most part, not extended to inpatient psychiatric services (Thibeault, Trudeau, d’Entremont, & Brown, 2010). It has been argued that in light of the lack of development in recent literature on psychiatric inpatient services, that it is indeed the “Cinderella of psychiatric services, suffering from neglect” (Baker, 2000, p. 95). Despite decreased availability of psychiatric hospital beds generally (Botha, Koen, Joska, Hering & Oosthuizen, 2010), there is growing acceptance for the demand for long term psychiatric inpatient care through the forensic psychiatric sector (Mars, Ramlall & Kalinski, 2012). Regardless of consensus that South African forensic psychiatric institutions operate well over capacity (Janse van Rensburg, 2012), limited empirical research is available for this sub-sector of psychiatric institutional life generally (Ryba, 2008; Seto, Harris & Rice, 2004).

The suggestion by the South African Society of Psychiatrists (SASOP) that rehabilitation must form the main emphasis of care presents clinicians with an immense challenge due to the limited research available on how to achieve this. A similar scenario within general psychiatric inpatient settings places clinicians and patients alike in a state of stagnancy bereft of positive purpose and benefit (Thibeault, et al., 2010). The view that long-term hospitalisation is no longer considered as ‘best practice’ for the treatment of acute mental illness (Thibeault, et al., 2010), surely does not negate the existence of sub-groups requiring the type of care that can only be offered through institutional care (Davis, Fulginiti, Kriegel & Brekke, 2012, Prins, 2011). It also belies acknowledgement of the importance that inpatient research holds for both policy and service development processes (Stenhouse, 2011).

The Fort England Hospital Buddy Programme (FEHBP) that is the focus of this research involves patients residing in a forensic chronic ward within a tertiary level psychiatric institution in Grahamstown, Eastern Cape, South Africa. The programme is student-led and involves third and fourth year participants from a local university (thus incorporating an element of non-professional, community involvement). The FEHBP operates within a two

hour long weekly framework, in which card games and other light-hearted, social activities are undertaken by its participants. It is largely unstructured in nature and the rationale underlying it is to provide patient participants with a non-professional, external source of contact outside of their hospital routines.

By employing an interpretative phenomenological analysis methodology (IPA) (Smith, 2004), the fundamental aim of this research is to explore the participant's subjective experience of the voluntary and informal ward activity. This is in keeping with general trends towards patient centred research in relation to mental health services, while extending it to the often overlooked long-term forensic inpatient population. It is hoped that this research will contribute to the dearth of literature relating to this psychiatric population sector. Additionally, through the subjective explorative and interpretative methodology chosen, an attempt is made to incorporate involvement of the mental health consumer (in this instance, male, forensic, psychiatric inpatients) in research involving one aspect of their ward life.

Literature Review

This chapter presents a review of the literature relevant to this research topic. It begins with an overview of mental health policy and moves to an overview of mental health care facilities in the Eastern Cape Province, as well as community-based treatment within the South African context. I discuss the forensic psychiatric context and a review of psychiatric inpatient literature is presented. Theories of social support will be introduced as a possible framework of understanding for non-professional support programmes, and practical examples of such programmes will be briefly discussed. Lastly, a description of the Fort England Hospital Buddy Programme (FEHBP) is provided.

Mental Health Policy

South African Context

As a developing country, South Africa faces substantial challenges in areas of unemployment and low income, poor housing, food insecurity, deprived education levels and a higher exposure to life events – all of which have been linked through research to an increased risk of the development of mental health problems (Draper et al., 2009; Kakuma, et al., 2010; Lund, Kleintjes, Kakuma, Flisher & the MHaPP Research Programme Consortium, 2010;). Van Wyk and colleagues (2010) maintain that the process of rapid urbanization currently occurring in South Africa further compounds the situation, resulting in difficulties that fall outside the realm of those attributed purely to economically associated challenges. Examples provided include “violence, substance abuse, child abuse, break up of traditional support networks and institutions, and the re-emergence of infectious diseases (e.g. tuberculosis and HIV – including resistant strains)” (Van Wyk, et al., 2010, p. 4). This is reiterated by Botha, et al. (2010, p. 2) who state that “high rates of unemployment, poor social circumstances, substance abuse and high levels of violence and crime further contribute to the unique challenge mental health services face in developing countries”. Thus, although the epidemiology of mental disorders in South Africa may be similar to other parts of the world (Van Wyk, et al., 2010), the erosion of already-stressed social and environmental resources leaves South Africa in a particularly precarious and vulnerable state with regard to mental health. One way which attempts to address this problem is through policy formulation.

Mental Health Policy Formulation

Mental Health Services (MHS) under South Africa's apartheid government were characterised by a combination of racial discrimination, paternalism, privatisation and institutionalisation (Freeman & Pillay, 1997). An inadequate, fragmented and under-resourced MHS was therefore unfortunately just another of the immense challenges inherited by the new democratic South Africa from the apartheid legacy (Freeman & Pillay, 1997; Lund, et al., 2010). The transformation from the apartheid era to a democratic state brought with it a shift in mental health policy – not just in relation to the actual policy formulation, but moreover, in the ideology and discourses that informed and shaped it (Freeman & Pillay, 1997; Petersen, 2000).

Whereas the previous Apartheid Mental Health Acts dealt almost exclusively with mental illness, the first of the African National Congress' (ANC) policy documents, the ANC's National Health Plan for South Africa (ANC, 1994) marked a shift towards a broader conceptualisation of mental health, including aspects of well-being over and above the predominantly biomedical and psychopharmacological treatment models that were the focus of previous policy formulation (Freeman & Pillay, 1997). The noticeable shift from the centralised and reactive systems of the past to a more decentralised and proactive approach were echoed in further mental health care procedures produced by the ANC government.

The White Paper for the Transformation of the Health System in South Africa (Department of Health, 1997) eventually led to the Mental Health Care Act of 2002 (Department of Health, 2004). Its preamble includes the following:

“Recognising that health is a state of physical, mental and social well-being and that mental health services should be provided as part of primary, secondary and tertiary health services ...that the Constitution of the Republic of South Africa, 1996, prohibits against unfair discrimination of people with mental or other disabilities, ... that there is a need to promote the provision of mental health care services in a manner which promotes the maximum mental well-being of users of mental health care services and communities in which they reside” (Department of Health, 2004).

The primary healthcare approach referred to above is further elaborated on within the act, where priority is placed on goals such as community empowerment, community-based treatment interventions, prevention of illness through education and the promotion of

individual and community well-being. Petersen (2000, p. 321) asserts that while there may be some debate about “what constitutes a sense of well-being across cultures, mental health is understood to refer to a state of physical, spiritual and emotional well-being which is determined not only by the physical disease process, but also by social, cultural and material conditions”. When one considers the multi-racial, multi-cultured and multi-layered levels of socio-economic functioning within South Africa, it becomes clear that a mental health service, or mental illness service, cannot operate within a vacuum, and must therefore be considered in relation to the broader context in which it occurs, and which it is to service.

South Africa’s Mental Health Policy formulation has attempted to address the complexity of the situation by moving towards a “broader discourse of understanding, one that understands illness as emerging out of an interaction of biological, cultural, psychological and social imperatives” (Hahn, 1995, as cited in Petersen, 2000, p. 322). It follows then that the array of complex contributing factors to the development of mental illness remains present in the multi-layered potential treatment and management options required. Thus, the emphasis that the act places on multiple levels of collaboration between legislative, professional, community and individuals is theoretically in line with its underlying discourse of inclusion, accessibility and acceptance.

Provision of Mental Health Facilities in the Eastern Cape

The psychiatric institution involved in this study is Fort England Hospital (FEH), a 313 bed tertiary institution, housing both forensic and general populations. The Maximum Security Unit caters for a national population, whereas the rest of the wards consist mainly of a provincial population. The hospital is situated in Grahamstown, Eastern Cape, South Africa.

The Eastern Cape is a large, predominantly rural province within South Africa which faces multiple challenges in numerous service delivery areas. In addition to geographical challenges faced in servicing a large, spread-out province with a sizable rural population, substantial trials remain in obtaining and managing the budget required to accommodate the high poverty and unemployment rates which characterise the province (Van Wyk, et al., 2010). Many of the existing facilities are dilapidated and in a bad state of repair, requiring urgent modifications to both physical and organisational structures, equipment and practices (Van Wyk, et al., 2010). Staff shortages are experienced at all levels of the provincial mental

health system, ranging from support and administrative staff to professional positions – particularly within the rural areas (Van Wyk, et al., 2010).

In relation to staff shortages at a professional level, a telephonic census carried out in April 2010 (Van Wyk, et al., 2010) revealed large deficits of mental health care professionals working within the state sector of the Eastern Cape (EC). For example, while there were 35 psychologists resident in the EC state sector in October 2010, it was estimated that a total of 84 were required in order to adequately provide for the mental health needs of the province. Similarly, it was found that there was a total of 13 psychiatrists, whereas it was estimated that approximately 108 psychiatrists would be a more accurate reflection of the psychiatric needs within the EC state sector (Van Wyk. et al., 2010). Furthermore, working on a provincial population where at least 80% - 85% of the 5.67 million people rely on state provided services, it leaves the state-employed psychiatrist/population ratio at approximately 1 : 436 000 (Van Wyk. et al., 2010). When one considers the reality of budget constraints and staff shortages, it is clear that policy shifts towards alternative methods incorporating community involvement are appropriate. However, when one views these unfortunate shortages in relation to the additional burden of mental illness prevalence rates in the province, the practical operationalization of these policies might be considered as essential.

The impact of problems such as staff shortages cannot fully be understood without taking a closer look at the communities the staff are required to serve. The prevalence rates of mental disorders within the Eastern Cape highlight how the difficulties already experienced are aggravated by staff shortages. According to calculations by Van Wyk, et al. (2010), one in seven persons aged fifteen years or older living in the Eastern Cape will have one or more of the following mental disorders per annum: schizophrenia, bipolar 1 disorder, depressive disorders, panic disorder, agoraphobia without panic, social phobia, generalised anxiety disorder, and post-traumatic stress disorder. This estimate should be considered as extremely conservative if one considers that the following disorders were not included in the calculations: “psychotic (other than schizophrenia), bipolar (other than type 1), specific phobia, adult separation anxiety, obsessive compulsive, attention deficit/hyperactivity, conduct, oppositional-defiant, substance-related, personality and dementia” (Van Wyk , et al., 2010, p. 4).

One in seven persons in the EC equals approximately 665 411 individuals who potentially will require and seek the assistance of state mental health services (Van Wyk, et al., 2010).

The Eastern Cape Department of Health (ECDoH) currently has provisions for approximately 1508 government psychiatric beds (Van Wyk, et al., 2010). The purpose of this example is to illustrate the dire shortages that the EC mental health services face. Whilst more could be written about the reasons underlying these deficits, the intention here is not to criticise, but rather to illustrate the immensity of the challenges that are faced, as well as to highlight the dire need for alternative forms of community-based and community-involved programmes to supplement the heavily burdened provincial mental health services.

Community-Based Treatment in South Africa

Despite efforts made by South Africa's mental health policy guidelines to address the immense hurdles it faces; a number of crucial procedural flaws have resulted in mental health maintaining a low priority on South Africa's public health agenda (Draper, et al, 2009; Foster, et al., 1997; Freeman & Pillay, 1997; Petersen, 2000; Skeen, et al., 2010). Research conducted by Bhana, Petersen, Baillie, Flisher, and the MHAPP Research Programme Consortium (2010) found that although South Africa has mental policy guidelines such as the Mental Health Care Act of 2002, lack of a formal mental health policy has resulted in uneven implementation across provinces. This was also linked to uneven funding, as mental health budgets are allocated according to the discretion of provincial Departments of Health (Lund, et al., 2010).

In addition to strained resources within the psychiatric institutional context as an unintended repercussion of deinstitutionalisation, Botha, et al. (2010, p. 462) refer to the following consequences: "large discrepancies in service delivery between different provinces, stigmatization of patients in the community, high levels of patient abuse, homelessness, recurrent readmissions to hospital of patients with severe mental illness". Furthermore, due to the under-sourcing of provincial and district mental health, only minor efforts are being made (mainly by NGO's limited to urban centres) towards expansion of psychosocial rehabilitation services and psycho education initiatives (Bhana, et al., 2010).

As in many other countries, it appears that the reduction of bed numbers that forms part of deinstitutionalisation has simply not been accompanied by the development of adequate alternate services (Lund, et al., 2010). More stringent admission policies have led to only the most severely ill patients being admitted, and at times, the premature discharge of patients

still requiring inpatient treatment in order to make room for those considered more in need of care (Botha, et al., 2010). Botha, et al. (2010) refer to this as the phenomena of the 'revolving door patient' (high frequency users who are repeatedly admitted to hospital due to only remaining well for limited periods of time).

Similarly, Bhana, et al. (2010, p. 602) comment that the deinstitutionalisation process in South Africa appears to have been characterised more by "de-hospitalisation rather than de-institutionalisation". They refer here specifically to the draining of funds for short term emergency management and symptom care, leaving little left over for the careful planning and implementation of longer term community-based care programmes.

While the development of community initiatives may have been achieved to some extent in areas such as those relating to the treatment of the HIV/AIDS epidemic (Horn, 2007; Kakuma, et al, 2010; Skeen, et al, 2010), or to mental health sectors containing a direct link to national economic outcome such as mining (Horn, 2007), much of South Africa's MHS remains confined to centralised, non-community-based psychiatric services where the focus is predominantly curative, rather than preventative (Freeman & Pillay, 1997; Lund, et al., 2010, 2006; Van Wyk, et al., 2010).

The lack of development of community based or involved treatment is unfortunate as research indicates that assertive community treatment "may not only reduce readmission rates in a setting with limited resources, but may also impact on the severity of psychopathology and level of functioning" (Botha, et al., 2010, p. 5). Not surprisingly, the same authors found that it was in the under-serviced areas (which could potentially most benefit from programmes of this nature) that these interventions were least likely to occur due to being unaffordable or perceived as not feasible.

Overview of Forensic Psychiatric Context in South Africa

In addition to a lack of appropriate resources (such as community-based treatment options), there is also mounting pressure on the forensic sub-sectors of psychiatric institutions to accommodate expanding patient numbers. The ward in which the Fort England Hospital Buddy Programme (FEHBP) takes place houses male, forensic psychiatric patients. Forensic patients in Fort England are admitted in one of the following ways. In South Africa, under the Criminal Procedure Act No 51 of 1977 (section 79), awaiting trial prisoners can be

referred for a 30 day observation period by a psychiatric panel if it is suspected that they are either unfit to stand trial or deemed not responsible for their crime by virtue of their mental illness/mental defect. The term 'state patient' is used to refer to defendants who are deemed not competent or not responsible and who are then referred to state psychiatric hospitals under section 28 of the Mental Health Care Act. In addition to state patients, forensic wards are also mandated to provide care for mentally ill prisoners, referred by prison facilities for treatment and symptom stabilisation. The same institutions involved in observations are usually also tasked with the care and treatment of state patients and mentally ill prisoners.

Mars, et al. (2012) point out that forensic institutions are just as resource-constrained as those operating within the general psychiatric context. They cited the example that in March 2010, 168 beds in 11 South African psychiatric institutions were available compared with the demand of 735 pre-trial detainees awaiting observation (Mars, et al., 2012). South African forensic psychiatric institutions operate well over capacity (Janse van Rensburg, 2012). One explanation for this is that there are essentially only three ways of dealing with forensic patients once their condition has improved (Janse van Rensburg, 2012). Patients can either be returned to their families (which is often the place where the offences occurred), a place can be secured for patients in the extremely limited half-way house options, or they can be referred to institutions for chronic care and rehabilitation (in addition to there being a limited selection of such institutions, they are plagued by poor infrastructure and staffing) (Janse van Rensburg, 2012).

Adding to the limited post-discharge options for forensic patients are the additional eligibility criteria required for consideration of discharge. While the traditional inpatient is usually discharged once stabilisation of their symptoms is achieved, the discharge of forensic patients is subject to a lengthy process that entails numerous additional criterion for consideration (Ryba, 2008). These include their risk to the community, the presence of risk factors within the community for relapse or reoffending, and the availability of placements (such as half-way houses or suitable custodians) outside of the institutional confines (Ryba, 2008). This implies that increased challenges/considerations for discharge of forensic patients may result in a decreased frequency of discharge for this sub sector of institutional population, thus leaving state patients that are for all intents and purposes, long term (possibly life-long) institutionalised patients.

Increased numbers of people with serious mental illness in the prison system

Along with the growth of forensic allocations and units in general inpatient psychiatric institutions, it has been observed by researchers that since deinstitutionalisation there has been an overrepresentation of people with mental illness in prison systems globally (Davis, Fulginiti, Kriegel & Brekke, 2012; Prins, 2011). This phenomenon has been described globally as ‘transinstitutionalisation’ due to the shift from psychiatric hospitals to other institutions such as prisons (Prins, 2011). The rationale behind this is that it appears that the current decentralised mental health system trend has generally served to benefit the middle class with less severe mental disorders, leaving those with serious mental illnesses more vulnerable due to decreased access to institutional care (Davis, et al., 2012).

It is argued that due to lack of appropriate primary and community-based facilities/treatment, people with mental illness may go undetected, and instead, be misdirected towards the prison system (Davis, et al., 2012). They posed the question that “if an individual with serious mental illness lives within the community and is socially isolated, physically ill and impoverished, does this represent successful deinstitutionalisation?” (p. 266). This particular question might be argued to hold particular significance for South Africa, where unemployment, low income, poor housing, food insecurity, low education levels and a higher exposure to life events have been linked to increased risk for the development of mental health problems (Draper et al., 2009; Skeen, et al., 2010).

Management of Forensic Patients

Despite an increasing demand for forensic facilities and an increasing numbers of patients that meet the classification criteria of forensic status (Ryba, 2008), there is general consensus that the idea of ‘reinstitutionalisation’ (increasing the number of beds in psychiatric hospitals) is not a feasible nor appropriate solution (Prins, 2011). In their position statement on state patients, the South African Society of Psychiatrists (SASOP) and State Employed Special Interest Group (SESIG) stated that rehabilitation must be the emphasis of care of state patients (Janse van Rensburg, 2012). While this statement may be theoretically sound, it is argued that it is not always an achievable reality due to the limited resources (on multiple tiers) that are discussed throughout this research. In addition, it brings forth additional new challenges regarding ways of achieving this for clinicians, as treatment within forensic hospitals has historically centred around stabilisation, symptom management and security concerns” (Ryba, 2008, p. 73) rather than rehabilitation.

Unfortunately, there is a dearth of empirical research that exists in relation to effective treatment strategies of state patients (Ryba, 2008; Seto, Harris & Rice, 2004) and offenders with mental illness (Morgan, et al., 2011). Literature found in this area all refer to examples within the United States of America and Canada. Thus, while there may be some contextual similarities or links that can be made with regard to the forensic context, the context of the Eastern Cape with its prevailing poverty and provision of resources would certainly differ vastly from the first world contexts of USA and Canada.

It has been argued that rehabilitative methods for a forensic psychiatric population are complicated by the fact that both psychiatric and correctional rehabilitation/treatment methods need to be incorporated (Morgan, et al., 2011). This may have implications for the depth of scope that researchers are required to cover. Additionally, research into this area may be further complicated by issues relating to resources (particularly, who will provide the funds for research in already resource-stressed areas such as the Eastern Cape), capacity (who is available to research this in a context where professional skills within the clinical environment are already considered a scarcity), and access (can researchers gain access to this psychiatric inpatient population sector). These considerations are addressed to some extent throughout this research, mostly in relation to ethics. However, they remain reflections on the part of the researcher in relation to individual experience due to the lack of available literature on the topic.

In what limited research has been produced, it appears that forensic psychiatric inpatients (state patients), or offenders with mental illness, benefit overall from personal interventions. In a research synthesis that examined 26 empirical studies drawn from 12,154 published and unpublished research documents, Morgan, et al. (2011) found that the interventions described and used within their meta-analysis appeared to effectively assist offenders with mental illness in reducing symptoms of distress, improving ability to cope, improved behaviour and increased adjustment to their surroundings. While the type of interventions used in the study varied, the majority of studies incorporated formalised or manualized approaches incorporating cognitive-behavioural elements such as homework, over a mean treatment time of 24.9 weeks (Morgan, et al., 2011).

However, the authors admitted perceived limitations in their findings due to the limited amount of usable studies which met their inclusion criteria consisting of a study design with a control procedure or repeated measure (only 26 out of 12,154). They thus concluded that the

results of their review further reinforced the notion that ‘usable’ research into treatment of offenders with mental illness was scarce - either as a result of these programmes not being developed, due to being under-researched, or not researched with enough rigour to inform practice through sufficient efficacy and effectiveness information.

Morgan, et al. 's (2011) research is based on the premise that the gold standard of research is true experimental design, that is, the use of randomised control tests in order to ascertain the efficacy of a treatment under controlled, experimental conditions. The provision of empirical support is thought to provide information on the likelihood of a treatment having positive effects within a clinical setting (effectiveness) (Kagee, 2006). However, doubts have been raised regarding the transportability of a purely scientific approach to a real world context. Swartz (2006, p. 253) maintains that “effectiveness studies are exceptionally difficult to conduct where the real world situation is much more complex and chaotic than in well-resourced health-care contexts”. Thus, it is pertinent to consider alternate methods of research to that considered to be gold standard, in order to investigate and explore necessary areas in chaotic and complex areas such as South Africa’s forensic psychiatric system. This research provides an example (as well as a review) of alternative approaches to the true experimental design. Another alternative that has been suggested for overcoming the lack of research in the area of forensic psychiatric patients is to generalise information from other population groups with similar characteristics.

Seto, et al. (2004) suggest that in light of limited available research, mental health professionals should draw on general inpatient literature for use with a forensic psychiatric population. The authors based this recommendation on the outcome of their comparison of the criminogenic, clinical and social problems of forensic and clinical committed psychiatric patients in Canada. Their findings indicated that the results gleaned from civil psychiatric patients could be cautiously generalised for use with a forensic psychiatric population. The suggestion of drawing on general inpatient literature may thus be one way of providing a reassuring straw to grasp for professionals working within this context. A review of this literature follows; however, it will be shown that unfortunately, recent literature pertaining to the psychiatric inpatient context is not without its own challenges.

Psychiatric Inpatient Literature

As referred to previously, de-institutionalisation within the psychiatric context has resulted in patients being viewed as consumers of mental health services (Bowers, 2005). The increased drive toward consumerism has brought with it a demand for further research from the perspective of the consumer, in this instance, users of psychiatric services (Bowers, 2005). However, it has been remarked by several global commentators that this shift has been to the detriment, rather than the advantage of inpatient psychiatric services. The Mental Health Act Commission of 1997 which investigated Britain's National Health Services commented that inpatient care was generally neglected (Baker, 2000). According to Bower (2005, p. 232) "Inpatient units have been left to drift with little research, little investment of clinical expertise, discussion and development, and no statement of their positive purpose and benefit". Due to long-term hospitalisation no longer considered as 'best practice' for the treatment of acute mental illness, discussion of the concept and role of the psychiatric milieu has almost disappeared from professional discourse" (Thibeault, et al., 2010, p. 217).

However, the lack of recent research interest does not negate the importance and the implications that research into the inpatient perspective holds for both policy and service development processes (Stenhouse, 2011). Although generalizable to most mental health professional roles, knowledge of patient experiences is a view point that appears to have been embraced by the psychiatric nursing profession (Stenhouse, 2011). In research set in an acute psychiatric ward in Scotland, Stenhouse (2011) found that patients on admission expected that they would be able to spend time talking with nurses in a therapeutic manner, however they perceived the nurses as being too busy to spend time with them. Although it emerged that the patients compensated for this by building relationships with and seeking counsel from fellow ward members, the findings had important implications for shaping service development of nurses within that ward.

In further research conducted in a locked psychiatric ward in Sweden, Johansson, Skarsater and Danielson (2006) found that the issue of control overshadowed the health care environment of the ward. On the basis of this, recommendations for strengthening the patient's position with regard to active participation in their own care were made. Baker (2000) argued that delivering psychosocial interventions (such as cognitive behavioural therapy, coping strategies and psycho education) to individuals with serious, chronic mental

illnesses within an inpatient setting achieved the dual purpose of benefitting patients, as well as enabling services to provide better and more effective care.

Jansson and Eklund (2002) point out that there is much research to support the existence of an important link between the social atmosphere in a psychiatric unit and the treatment outcome of the patient. Similarly, Thibeault, et al. (2010) argue that it is critical to understand the inpatient ward milieu because of the impact it has on the well-being, potential for recovery, behaviour and long term health outcomes of the patient. In their inquiry, they found that according to participating patients, it is the person-to-person interaction within the inpatient setting that holds meaning for them, in other words, “when asked about to talk about the environment, patients wanted to talk about interaction” (Thibeault, et al., 2010, p. 220). This finding implied that it would benefit patients if mental health nurses focused on strengthening processes that served to increase a “sense of connectedness, engagement and affirmation” (Thibeault, et al., 2010, p. 226). Social engagement with the nurses was thus seen by the patients as a legitimate healthcare need (Thibeault, et al., 2010) and as a contributing factor to their overall satisfaction with the care provided for them. This may have important implications for successful rehabilitation (of forensic or general psychiatric inpatient populations) as it has been shown that satisfaction with care is viewed as a predictor of outcome (Shiva, Haden & Brooks, 2009).

Within acute psychiatric contexts, traditional forms of social engagement or self-expression may be challenging due to reasons that are either illness or medication side effects related. Art therapy is a professional psychological intervention that has been used and researched within acute psychiatric contexts. A study that attempted to review art therapy as a potential treatment for schizophrenia in relation to standard care and other psychosocial interventions found only 2 studies (out of a total of 61) that fulfilled the criteria of utilising randomised controlled trials (RCT) (Ruddy & Milnes, 2009). The authors did however assert that despite the small number of RCT's evident, they were nevertheless of the opinion that randomised studies were a feasible possibility within the field (Ruddy & Milnes, 2009). Furthermore, the two studies failed to include sufficient research participants required to draw meaningful results, leading to problems with generalizability and a subsequent lack of clear conclusions with regards to the applicability of art therapy for use within inpatient populations diagnosed with schizophrenia (Ruddy & Milnes, 2009). Similarly, authors (Ruddy & Dent-Brown, 2007) cautioned about the use of drama therapy as an intervention within psychiatric

inpatient populations, asserting that the positive (benefits) or negative effects (harm) of drama therapy were as yet unknown.

An important element of inpatient care, and one that is of crucial relevance to this research topic, is that of perceived social context. The FEHBP being researched is an example of an attempt to add diversity to the potential array of social interactions that patients may encounter within long term institutional life. In addition to this, it illustrates the utilisation of volunteer, non-professional community members within a resource-conscious context as a potential alternative avenue for inpatient support in a social form. A theoretical overview of social support and its various components is provided in the next section.

Social Support

Social relationships deemed to be of value to an individual have been shown to promote subjective well-being, as well as to reduce perceived levels of stress (Cohen, 2004; Ditzen, Schmidt, Strauss, Nater, Ehlert, Heinrichs, 2008). In a conceptual analysis of research spanning back to the 1970s, Langford, et al. (1997) sought to identify the most frequently used theoretical and operational definitions of social support. The authors remarked that the studies identified “reflected an interest in social support across all age groups and include both disease-related and health-related topics” (p. 95).

In a study which sought to determine the efficacy of social support interventions (Hogan, Wolfgang & Bahman, 2002), the authors utilised a computerized search strategy to evaluate 100 published studies. Studies investigated the usefulness of social support in difficulties as diverse as “cancer, loneliness, weight loss, substance abuse, lack in parenting skills, surgery and birth preparation” (p. 381). Overall, the review provided support for the usefulness of social support interventions. Furthermore, the study highlighted the importance of the subjective, perceived value of social support to the individual as a potential negative outcome related to social support when perceived as unhelpful by the individual. In another study (Ditzen, et al., 2008), found that a combination of adult attachment styles (such as secure insecure or ambivalent), combined with a perceived level of social support contributed to either an increase or decrease in psychological responses to psychosocial stress.

Defining Social Support

Cobb (1976, p. 300) defined social support as “information leading the subject to believe that he or she is loved, esteemed, and belongs to a network of mutual obligation.” Cassel (1976) looked at social support in relation to the degree of ‘embeddedness’ (sense of belonging and relatedness) within a social network. Although Cobb (1976) differed slightly from other researchers at the time in that he did not specifically refer to assistance in terms of provision of goods or services, the element of reciprocity remained consistent amongst researchers (Langford, et al., 1999). Within the early seminal literature, there appeared to be consensus regarding Wortman and Dunkel-Schetter’s (1979) concept of the protective factor of social support (Langford, et al., 1999), and it was widely acknowledged as having the ability to “shield others, especially individuals, from the adverse effects of life stress” (Langford, et al., 1997, p. 96).

Theoretical Foundations

The theoretical foundations of social support are largely acknowledged to have originated from within theories of social comparison, social exchange and social competence (Langford, et al., 1997). Briefly, according to social comparison theory, it is through a process of comparison with others, that individuals develop their sense of self-concept (Langford, et al., 1997). This in turn can affect an individual’s ability to experience engagement with others, and thus, by implication, mutually rewarding behaviours and activities (Langford, et al., 1997). Once again, the mutual concept of reciprocity emerges in that in order to experience social support there is some degree of active participation required in both giving and receiving (Langford, et al., 1997). In order for social exchange to take place, a degree of social competence is implied. In other words, an individual’s ability to effectively engage in mutually rewarding social interactions is an essential part of social health (Stewart, 1993 cited in Langford, et al., 1997). Rather than there being one dominant theory, the above mentioned social theories are fluid, interactive and interdependent. As Langford, et al. (1997) asserts, “it is within a positive social climate of assistance and protection that the theoretical foundations of social comparison, social exchange and social competence operate” (p. 96).

In order to create a positive social context, a fluid (and subjectively valued) interplay of several factors is required. Social networks are considered as the vehicle through which social support is provided (Langford, et al., 1997). Social embeddedness (Cassel, 1976) is used to

refer to the level or degree of connectedness that an individual possesses in relation to significant others within their social network and social climate denotes the level of positive, protective and helpful factors associated with social support that is deemed beneficial by the individual (Langford et al., 1997). “Without a structure of people (network) with the quality of connectedness (embeddedness) required to generate an atmosphere of helpfulness and protection (social climate), social supportive behaviours cannot occur” (Langford, et al., 1997, p. 97).

The Buffering and Main Effects Models

Although the area of research into social support consists predominantly of two main schools of thought (namely, the buffering and main effects models), Cohen and Wills (1985) found evidence to support both ways of hypothesizing the links between stress and social support. The former model posits that social supports function as a ‘buffer’ (means of protection) that can be used during times of stressful events, whereas the latter infers that supportive social relationships have a direct bearing on an individual’s health at all times. Within the buffering model, researchers found evidence to support the notion that it is the “perceived availability of interpersonal resources that are responsive to the needs elicited by stressful events” that acts as a buffer to individuals in times of crisis (Cohen & Wills, 1985, p. 310).

The same researchers also found evidence in support of the main effects model, that it is an individual’s on-going (as opposed to limited to times of crisis) “degree of integration in a large social network” that has an effect on an individual’s sustained perception of their own sense of general well-being (Cohen & Wills, 1985, p. 310). They suggest that rather than be considered as opposing, each hypothesis should be considered as context specific. In other words, a particular hypothesis might be considered as more relevant or appropriate, depending on the health situation in question. For example, the main effects model has been found to be particularly useful in and applicable to a health and wellness context (Dunkel Schetter & Brooks, 2009), as opposed to a disease and coping with sudden onset of illness context.

Attributes of social support:

Researchers divide social support into four main categories of attributes: emotional, instrumental, informational and appraisal support (Langford, et al., 1997). Emotional support refers to acts such as “listening, providing empathy and understanding and showing

affection” (Dunkel Schetter & Brooks, 2009, p. 1566). Emotional support has been referred to by other authors (Khan & Antonucci, 1980; Norbeck, et al., 1981 cited in Langford, et al., 1997, p. 96) as ‘affective assistance’, that is, a transaction which “imparts liking, admiration, respect and love”.

Instrumental support (alternatively referred to as tangible support) involves “the provision of material resources or task assistance” (Dunkel Schetter & Brooks, 2009, p. 1566). As indicated by Langford, et al.(1997), although instrumental support may be considered to be suggestive of a level of caring and love for an individual, it is in fact considered as a distinct and separate entity to emotional support. Similar to instrumental support, informational support involves the sharing of information relevant to a crisis situation to individuals (House, Umberson & Landis, 1988). Interestingly, although emotional support is continuously listed by respondents as being of high self-perceived value (House et al., 1988), informational support is often considered unhelpful or unwanted (Dunkel Schetter & Brooks, 2009).

Finally, appraisal support, or affirmational support (Khan & Antonucci, 1988 cited in Langford, et al., 1997) refers to the communication of information that pertains to self-evaluation of the individual, rather than to the appropriate problem solving methods associated with the objectives underlying informational support (House, et al., 1988). In other words, it is a support which “encompasses expressions that affirm the appropriateness of acts or statements made by another” (Langford, et al., 1997, p. 97).

While a direct link to social support theories is not necessarily made by authors researching forms of non-professional support, it is argued that the use of some sort of external contact, whether it is in the form of pet-centred interventions or yoga, introduces an additional element (one that is potentially socially supportive) to the ward milieu of individuals residing within an institutional environment. The following section reviews examples of non-professional support programmes.

Practical examples of ‘non-professional’ support

In this instance, the term ‘nonprofessional’ is used to refer to individuals or groups outside of the professional staff within the traditionally-considered clinical realm (such as psychiatrists, doctors, psychologists, occupational therapists and social workers). Literature relating to the

practical involvement of external nonprofessional support/community initiatives/programmes in the care of chronic psychiatric inpatients is largely considered in need of further investigation, or affected by methodological concerns (Lavey, Sherman, Mueser, Osborne, Currier & Wolfe, 2005; Ruddy & Dent-Brown, 2007; Ruddy & Milnes, 2009).

A survey of the literature produced research studies which explored topics such as: assessing animal or pet centred interventions for old age-related dementia inpatient samples (Colombo, Buono, Smania, Raviola & De Leo, 2006; Walsh, Mertin, Verlander & Pollard, 1995), drama groups for clinical populations (Ruddy & Dent-Brown, 2007), general exercise interventions within clinical settings (Stathopoulou, Powers, Berry, Smits, & Otto, 2006), and yoga on inpatient samples (Lavey, et al., 2005).

Two studies investigating the efficacy of pet-centred interventions concluded that it appeared that the use of pets in old age psychiatric inpatient settings were largely beneficial to its participants and staff. In their study, Colombo, et al., (2006) provided 48 participants with a canary, 34 with a plant and 53 with nothing. Results gleaned at the end of a three month observation period showed a significant improvement in well-being (including depressive symptoms and perceptions of quality of life) in the canary sample group. Similarly, Walsh, et al., 1995 found that regular contact with a dog resulted in significant positive changes in heart rate, as well as substantial drops in the noise levels in the ward housing the experimental group of participants. The results of both studies appeared to lend further credence to extant literature in support of the use of pets within psychiatric inpatient settings.

Similarly, the findings of a study investigating the efficacy of exercise as part of a treatment programme for psychiatric inpatients yielded results in support of existing literature. Based on a meta-analysis of 11 studies researching the treatment outcome of individuals with depression residing within a clinical environment, authors provided encouragement to clinicians to consider the use of exercise as a complementary intervention within clinical practice (Stathopoulou, et al., 2006).

Authors of a study on yoga (Lavey, et al., 2005) ascertained that inpatient participants in the yoga activity reported significant improvements in mood elements such as tension-anxiety, depression-dejection, anger-hostility, fatigue-inertia and confusion-bewilderment. However, due to little difference in variance reported by those who participated in several classes and those who participated in just one class, the authors conceded that improved mood may not be solely as a result of yoga: “taking a break from the routine of inpatient treatment, and

sharing in a relaxing, non-socially demanding experience may confer major benefits in terms of negative mood, even in the absence of formal learning of yoga techniques” (Lavey, et al., 2005, p. 401).

Of particular interest (or perhaps significance) with regard to the South African context, literature in support of the theoretical significance of inclusion of nonprofessional support is readily accessible (Draper, et al., 2009; Skeen, et al., 2010). However, unfortunately no literature outlining practical examples in relation to institutionalized chronic psychiatric patients and nonprofessional support initiatives/programmes could be found by the researcher. In addition to the practical and ethical considerations such as barriers to access and obtaining informed consent of vulnerable, incarcerated psychiatric patients (Benatar, 2002; Van Staden, 2007), it is acknowledged that the additional criterion of ‘forensic’ patient status may complicate these considerations further. Additionally, all of the above might function to provide possible explanations for why such initiatives (if they are in existence) remain either un-formalized, un-researched, or unpublished.

The Fort England Hospital Buddy Programme (FEHBP)

Unfortunately no official documentation exists in relation to the FEHBP. Information pertaining to its origins and history were obtained during an interview with Mr. Iain Reid, Head of Psychology at Fort England Hospital (FEH) (personal communication, March 6, 2012). According to Reid the FEHBP was originally started as a joint exercise between FEH and the Rhodes University Centre for Social Development. Although the basic operationalization of the FEHBP has altered over the years, essentially, the original aim was to provide external contact and support to long-term ward patients who had limited contact with family or outside visitors. The nature of the support was not intended to form part of professional services provided at the hospital, or to substitute the practice of therapy (psychological or occupational) within the patient’s treatment schedules. It has however been surmised that although not intentionally therapeutic in objective, the personal attention and relationships formed between the students and patients may inadvertently carry some degree of therapeutic gain (I. Reid, personal communication, March 6, 2012).

With its inception in the early 1990’s, the FEHBP was run in one of the long-term chronic psychiatric mixed-gender wards at the hospital. The programme was originally headed up by

the Rhodes University Centre for Social Development, with contributors made up predominantly of Rhodes University students. However, involvement was not limited to Department of Psychology students, thus learners from any faculty could participate. Each participant was assigned to a patient, who they visited weekly for an hour at a time.

Unfortunately, the programme was interrupted for several years, largely due to policy changes that resulted in the demographics of Fort England Hospital (FEH) shifting from general to majority forensic wards. During 2010, the FEHBP was resurrected through the cooperation of the Rhodes Psychology Department. The forensic aspect brought with it new dimensions and concerns relating to the safety of the students, as well as the suitability of the FEHBP for the patients. Ethics and safety concerns were further compounded by the operational changes that a forensic ward brought with it. It is largely accepted that the therapeutic milieu in a forensic hospital (as opposed to a general psychiatric hospital) rests predominantly upon structure, routine and rules (Ryba, 2008). The use of groups (for example, such as those for medication education, insight, addiction and rehabilitation) “are frequently used tools in inpatient forensic treatment” (Ryba, 2008, p. 74).

Thus, when an attempt to resurrect the FEHBP was made in 2010, changes to accommodate the forensic capacity of the ward were required. Under the supervision of a Forensic Psychologist from FEH, permission was granted for the students to have access to patients in a ward which housed male, forensic, chronic psychiatric patients. It was decided to operate the FEHBP as a group activity (rather than an individual, one-on-one system). Thus, the students entered the ward as a group and conducted activities with a group of willing patient participants.

The multidisciplinary FEH staff was responsible for continually assessing the programme participants; should a patient be deemed as actively mentally ill, then their participation was not allowed until such time as their symptoms had stabilised (I. Reid, personal communication, March 30, 2012). In addition, FEH’s Behavioural Modification Programme (BMP) also assisted with this to a degree, as only patients within group A had access to the FEHBP. Without digressing too far, in the BMP patients progress through a succession of categories from C (least desirable) to A (most desirable). Upward movement is dependent upon the level of appropriate behaviour that each patient demonstrates on the ward. Each group elevation brings with it increased privileges; for instance, choice of participation in activities such as the FEHBP. In addition to encouraging and maintaining order within the

ward, the BMP functions as a “downward risk escalator, aiming to gradually progress patients from safety towards autonomy in relatively small, easy stages” (Heyman, Shaw, Davies, Godin, & Reynolds, 2004, p. 312). Thus, access to participation in the FEHBP occurs at a stage where the patient is deemed able to do so, both with regard to physical participation as well as consent.

Additionally, the forensic aspect of the ward brought with it further concerns regarding the confidentiality of the patient participants. Thus, all student participants were required to undergo an introduction with one of the psychologists at FEH, where the importance of patient confidentiality was highlighted. The students were also required to sign FEH confidentiality contracts. Patient and student participation in the programme was completely voluntary, and whereas students were required to commit to an annual participation in the FEHBP (with the exception of University-decided holidays), the patients could decide their participation on a weekly basis, depending on their inclination (as well as mental status and position within BMP). In keeping with the journey towards potential autonomy marked by the patient’s position within the BMP (and their subsequent access to participation in the FEHBP), voluntary participation on the part of the patient was considered not just appropriate, but absolutely necessary.

Activities within the programme consist mainly of playing of card games (poker, crazy eights, uno) and board games (snakes and ladders). On occasion alternate activities such as origami (paper folding), soccer, pin the tail on the donkey and collage-making were incorporated into the programme. In 2011, fundraising initiatives by the RU students enabled the addition of music (in the form of a CD player and CDs requested by the patients). This enabled a further role-taking and responsibility dimension, as positions emerged for a weekly disc jockey, as well as technical set up crew (approaching nursing staff for required plugs and adaptor and ensuring that the CD player was in working order).

Further Information on the FEHBP Rationale

The rationale underlying the FEHBP was multi-faceted in nature. As Jansson and Eklund (2002) assert, although not necessarily considered a formal part of treatment, the relationship between the in-ward social atmosphere and results of treatment is not by any means a new idea within psychiatry. Support provided through positive social exchanges within the context of the inpatient milieu, including those which may occur in residential programmes or patient clubhouses/games rooms have been viewed as being of benefit to patients (Davidson,

Chinman, Sells & Rowe 2006). The idea of the FEHBP was thus viewed as a positive addition to the ward environment by the professional staff.

In addition to theoretical benefits, conceptualisation of the FEHBP brought with it potential economic and practical benefits. It was felt that incorporating the student-led FEHBP was an accessible way of lessening the burden of limited resources, which resulted in staff shortages as well as severe time constraints on the professional staff employed. The participation of psychology student volunteers was an attempt to bridge the gap between the general community, or lay person, and professional realm. Although the students formed part of the local community (and thus lacked experience within a clinical environment), each student had a minimum three years' worth of psychological theoretical knowledge. This served to diminish the need for extensive training (for example, in areas such as confidentiality or fundamentals relating to mental illness). In addition to this, it diminished the need for close supervision. Had either of these been required, it may have defeated the purpose of lessening the strain on already stretched resources. Lastly, the proposed relationship between students and patients was theoretically mutually beneficial, providing patients with additional contact and access to ward activities, and enabling students to benefit from the experience of exposure to working within a clinical environment. The key element of a sense of reciprocity to social support systems (Langford, et al., 1997) was thus present for both the student and patient participants.

Through the surface level aim of external contact, a degree of novelty was allowed to filter into the weekly ward routines of patients. The FEHBP provided both student and patient volunteers with access to a different sort of social interaction than they would normally encounter during their routine daily circles. Thus, a flexible approach to interaction (encompassing requirements such as tolerance and a certain degree of openness and willingness to engage with others) was indirectly fostered throughout the annual course of the FEHBP. Similarly, the activities (such as card and music playing, dancing and soccer) assisted to further facilitate interaction between student and patient participants. A large number of the activities were conducive to teaching, and (as one example of interaction) to be experienced bi-directionally between patient and student volunteers. For example, the patient participants appeared to revel in teaching students how to play the 'crazy eights' card game, whereas the students delighted in initially leading the way in games, such as Jenga, which was unknown to the majority of patients. Furthermore, the end of semester parties which occurred twice a year provided patients with variety and opportunities for a more relaxed

style of social interaction. During these much anticipated parties, eats which the patients would not normally have regular access to (such as cakes, sweets, ice cream, crisps and fizzy cool drinks) were served in abundance. The attention was shifted from games playing to eating, socialising and dancing to music.

Methodology

This chapter provides an outline of the methodological, procedural and ethical considerations that were employed throughout this process by the researcher. The section on interpretative phenomenological analysis (IPA) methodology includes a discussion of the theoretical origins and principles underlying this theory. Sections on research aims, participants, sampling, collection of material, analysis of material, and validity, reliability and ethical considerations are outlined and discussed. A detailed account of the procedure followed is discussed both within and in relation to each section.

i) Research aims, purpose and design

The purpose of this research is first and foremost to explore the subjective experience of institutionalized forensic psychiatric inpatients' involvement in an informal student-led programme, the FEHBP. It is hoped that this research may contribute positively to the lack of literature relating to long-term institutionalised psychiatric inpatients' subjective experience, with additional emphasis placed on further criteria of 'forensic psychiatric patient' and 'community involvement/non-professional initiatives/programmes'.

As this research seeks to explore the subjective experience of patients in relation to the FEHBP, it will fall within a naturalistic qualitative framework of enquiry. The research methodology used will be Smith's IPA as this particular approach is deemed suitable for when "one is trying to find out how individuals are perceiving the particular situations they are facing and how they are making sense of their personal and social world" (Smith & Osborn, 2003, p. 55).

Introduction to IPA

Developed by Jonathan Smith (1996), the primary concern of IPA is to achieve a "detailed examination of the individual lived experience and how individuals make sense of that lived experience" (Eatough & Smith, 2008, p. 179). An assumption in IPA is that "the analyst is interested in learning something about the respondent's psychological world" (Smith & Osborn, 2003, p. 66). One of the key aims is to contribute to psychology through providing

new perspectives on existing research, or to identify new areas for future research (Smith, 2004). The results of an analysis are therefore not viewed in isolation, but rather are engaged with and discussed in relation to the extant psychological literature (Smith, 2004, p. 44). In other words, “the power of the IPA study is judged by the light it sheds within the broader context of readers, who make links between the findings of an IPA study, their own personal experience, and the claims of the extant literature” (Smith & Osborn, 2003, p. 56).

IPA is bound by competing principles, stemming from its roots in phenomenological, hermeneutical and ideographical epistemologies. Whilst Smith (2004) describes the theoretical position of IPA as developing from two predominant sources, namely phenomenological (Giorgi, 1995; cited in Smith, 2004) and hermeneutical (Palmer, 1969, cited in Smith, 2004), a third dimension of symbolic interactionism has been referred to by others (Denzin, 1995; cited in Smith & Osborne, 2003). Denzin (1995; cited in Smith & Osborne, 2003) asserts that symbolic interactionism is relevant to IPA as it assumes that through social interaction and dialogue individuals can make sense of, and derive meaning from their own experiences. . In referring to the complicated connection between people’s talk, thinking and emotional state, Smith (2004, p. 54) is of the opinion that “people struggle to express what they are thinking and feeling ... the researcher has to interpret people’s mental and emotional state from what they say”.

While both approaches acknowledge an individual’s ability to form meaning, IPA differs from symbolic interactionism with regard to the level of meaning that can be expressed and the researcher’s role in interpretation and exploration of meaning. It is thus argued that no stage of IPA research is viewed as a passive process for the researcher, participant or reader. In addition to “describing a corpus of empirical research” and providing “a set of guidelines for conducting research”, Smith (2004, p. 40) asserts that IPA is an epistemological position.

Phenomenological influence

Through the acknowledgement that reality is derived from a verb which means ‘to think’, Edmund Husserl, (the founder of the phenomenological approach) broke away from the positivist orientation of his time by offering a new interpretation of the concept of reality (Larkin, Watts & Clifton, 2006). In doing so, he questioned the notion of whether or not a reality exists outside of our minds or our thoughts (Larkin, et al., 2006). He argued that individuals are the creators of their own subjective realities and their thoughts and perceptions shape the reality of what they feel in any given situation (Larkin et al., 2006). In

other words, those individuals have “perspectives of their own world” (Kvale, 1996, p. 53, cited in Larkin, et al., 2006).

IPA is similar to phenomenology in that as qualitative methodologies, both research processes begin with a vague or naive description of an experience, followed by processes of meaning extraction and reflection from the researcher (Willig, 2007). Likewise, neither approach attempts to situate experience into predefined or overly abstract categories (Smith & Osborne, 2003). Although parallels between phenomenology and IPA exist in that both seek to understand the experience of the individual participant on some level, IPA differs in that it accepts and embraces the interpretative and at times interrogative role of the researcher in the research process and outcome (Smith, 2004).

Hermeneutical influence

The theoretical anomaly that exists within IPA, that of interpretative versus phenomenological, is further shadowed on a practical level by the constant fluctuation required between the hermeneutics of empathy and hermeneutics of questioning, resulting in an ever-present double hermeneutic (Smith, 2004). Hermeneutic approaches take into account the fullest levels of interpretation possible (Larkin, et al., 2006). Although the subjective experience of interpretation of the individual participant is taken into consideration, the interpretative (and hence subjective) role of the researcher in the research process is accepted and acknowledged (Larkin, et al., 2006):

“Hermeneutic approaches view the knower and the known as fundamentally interrelated, and thus assume that any interpretation necessarily involves an essential circularity of understanding – a hermeneutic circle in which the interpreter’s perspective and understanding initially shapes his interpretation of a given phenomenon, and yet that interpretation, as it interacts with the phenomenon in question, is open to revision and elaboration, as the perspective and understanding of the interpreter, including his biases and blind spots, are revealed and evaluated”. (Tappan, 1996, p.657, cited in Larkin et al., 2006)

The IPA researcher is trying to make sense of the participants attempt at sense-making of their own life world (Smith & Osborn, 2003). In other words, researchers are actively providing an interpretation of what it means for a particular participant to have a particular experience within a particular context. This process could be referred to as being two pronged; in order to empathise with the participants and their thoughts and feelings with regard to their own context, an “empathic hermeneutic” (Smith & Osborne, 2003, p. 53) is required. On the other hand, in order to make sense of the participant’s making sense

process, a “questioning hermeneutic” (Smith, 2004, p. 40) is required. Referred to as a “double hermeneutic” (Smith, 2004, p. 40), this term encapsulates the circular processes involved in the phenomenological research progression between participant and researcher.

Hermeneutics of empathy and questioning are required to be balanced in such a way as to ensure that the end product or research outcome maintains a close relationship to the participant’s original experience (Larkin, et al., 2006). In this balancing act, the researcher is required to conduct not just the “generation of an insider’s account, but it also requires that meaning and commonality are sought beyond that point” (Larkin, et al., 2006, p. 115).

Thus, in addition to the commitment to ‘give voice’ to participant concerns, IPA, as an inductive and flexible approach (Reid, Flowers & Larkin, 2005; Smith, 2004), maintains a commitment to “the interpretative requirement to contextualize and make sense of these claims and concerns from a psychological perspective” (Larkin, et al., 2006, p. 102). IPA research attempts to shed light on or within the broader context (Smith & Osborn, 2003). Smith (2004, p. 45) recommends that interpretation is “informed by a general psychological interest, but without being influenced by a specific pre-existing formal theoretical position”. While supporting the phenomenology of the participant’s subjective experience is one element, maintaining openness to what emerges from the material, and thus, not being limited or directed by pre-existing theoretical knowledge, is another (Smith & Osborn, 2003).

Researcher Reflection on Personal Embeddedness

The general psychological interest informing this research is primarily to attempt to gain insight into how forensic psychiatric patients experience an informal, student-led initiative, the FEHBP. The goal therefore on a surface level was to use IPA as a methodology to gain “renewed insight into the phenomenon at hand – informed by the participant’s own relatedness to, and engagement with, that phenomenon” (Larkin, et al., 2006, p. 117).

However, considering IPA epistemologically, the attempt at gaining renewed insight went hand in hand with the acknowledgement that it is not possible for a researcher to remove “oneself, thoughts and meaning systems from the world, in order to find out how things ‘really are’ in some definitive sense” (Larkin, et al., 2006, p. 106). Underlying the research process was thus an open and necessary acceptance that the participant’s ‘lived experience’ is coupled with a subjective and reflective process of interpretation, in which the analyst explicitly enters into the research process” (Reid, et al., 2005, p. 20).

Although the methodological and epistemological positions referred to throughout this thesis might be intended conventionally to refer to research processes generally, in the case of this research, it enters explicitly into a need for practical consideration and debate. The researcher was a student participant in the FEHBP for a period of 2 years (during 2010, 2011) prior to the commencement of conducting this research (during 2012-2013). It was her involvement in the FEHBP that inspired the desire to engage with it as a research topic. Additionally, it was her subjectivity with regard to the patient participants (and the relationships formed with the participants over the two year period) that informed the use of IPA as a methodological and epistemological stance. Rather than any number of alternative ways available to approach the topic (for example, quantitatively or through programme evaluation), the desire to gain insight into the patient's subjective experience of the FEHBP was informed by the researcher's prior experience within the programme.

Two out of the three research participants were active in the FEHBP during the time when the researcher was a student participant. The researcher was thus known to (and recognised by) the research participants during the recruitment stage, following onto the material collection stages. It is understandable that concerns of bias relating to the familiarity of the researcher might arise, either with regard to coercion to participate or in terms of influencing the answers provided by the participants. However, (although this point could be open to a theoretical debate), it was the experience of the researcher that the opposite of this was true. "The ability to establish a sense of trust is considered to be central to seeking an understanding of the phenomena under study and to the richness of the material that unfolds" (Moyle, 2002, p. 270). It is hypothesized that as one of the main aims of the FEHBP is to encourage non-judgement, openness and expression of individuality amongst the participants, that through identification with the researcher as having once been a part of the FEHBP, there was an easy and open rapport established between the research participants and researcher. As the purpose of this research is to explore the subjective experience of the participants, (rather than to evaluate the FEHBP) it is argued that the familiarity of the researcher to some of the participants appeared to assist in enabling open exploration by way of the approachable relationship previously established.

Another point to consider is that the very nature of the FEHBP depends on it being completely voluntary. It is thus argued that this may have extended into the recruitment and material collection processes, as the participants expressed their enjoyment of the material collection interviews and readily consented to participate in a second set of interviews a year

after their initial interviews. Admittedly, a possibly justified criticism might be that researcher and participant familiarity may potentially have skewed material to contain more affirmative responses relating to the FEHBP. However, in the greater scheme of things, or in relation to a cost-benefit analysis (Smith, 2004), it is felt that the positives of the researcher's previous involvement in the FEHBP outweighed the negatives sufficiently to justify the continuation of research.

Another role of the researcher which might be argued to have had a potentially negative role in influencing the material collected is that of Intern Clinical Psychologists working at FEH during the second year of this research process (2013). This may be especially relevant in light of the material that emerged from the participants wherein they expressed an open awareness of the various roles, and the differences between various staff members such as psychologists. It was the experience of the researcher that the research participants identified with her in relation to their knowledge of her experience within the FEHBP rather than as an Intern Clinical Psychologist. Additionally, it should be noted that the researcher did not work within a professional capacity on the participant's ward at any stage throughout the research process and thus her role there was confined to or contained as researcher. It is however argued that the researcher's role as an intern clinical psychologist, in this particular instance, did provide her with experience (and thus greater comfort, confidence and skill) in interviewing and working within a clinical environment. This was perceived as advantageous, as the interviews conducted during 2013 elicited a far greater depth of information than those in 2012.

However, despite the perceived identification by the participants with the researcher in relation to her roles as past student volunteer and current FEHBP researcher, the possible privileges afforded in the research process due to her roles as first year clinical psychology masters (2012) and then intern clinical psychologist (2013) cannot be ignored. The challenges to obtaining access to populations deemed vulnerable to exploitation have been well documented (Moore & Miller, 1999 cited in Hayes, 2006). Although this will be explored in greater depth during the ethics section of this chapter, it is sufficient for present purposes to acknowledge that the researcher's position, both academically and professionally within FEH may have afforded her an easier and/or time efficient entry into gaining access/permission to research this population. (The concept of potential privilege may be further illustrated by imagining that the same research scenario and request for access to the this population is posed by someone from outside the clinical, psychiatric environment, and

whether any obstacles would have been evident in obtaining the necessary permission for access).

It is acknowledged that there were multiple roles at play with in this research - researcher, practitioner, student and participant, and that each role brought with it multiple potential benefits and setbacks. While the experience, knowledge and vantage points gained from any of the roles of the researcher could not lay claim to being objectively deferred at will, it is hoped that a process of reflexivity and sensitivity to the research participants as well as the subject assisted in protecting both.

IPA as methodology of choice for healthcare

In addition to motivations of theoretical, personal and practical suitability, it is felt that the appropriateness of the IPA methodology for this research is further reinforced through the context of healthcare in which it is situated. Biggerstaff and Thomson (2008, p. 173) hold the view that the suitability of IPA as a “research tool in understanding healthcare and illness from the patient perspective” was due to its “essential simplicity, paradoxical complexity and methodological rigour”. A subjective, explorative methodology provides an opportunity to incorporate the mental health services consumer (in this instance male, forensic, psychiatric inpatients) into research involving an aspect of their ward life. This is in keeping with general trends towards patient centred research in relation to mental health services, while likewise extending it to the often overlooked long-term forensic inpatient population.

Furthermore, the authors of a review of 52 academic articles which incorporated an IPA methodology (Brocki & Wearden, 2006) cautioned against the lack of attention sometimes afforded by researchers to the interpretative component of the approach. Although the authors conceded that IPA appeared to be useful and applicable in a wide range of research topics within the arena of health psychology they found that some authors did not appear to have successfully balanced the tensions between the subjective experience of the participant and interpretation of that experience, resulting in what Smith (2004) refers to as a first level analyses, meaning lacking depth. Alternatively, as is the case in Flowers, Hart and Marricott (1999), flexibility to formal theoretical positions may allow the opportunity to draw attention to the shortcomings in pre-existing psychological theory.

ii) Participants

This research sought to explore solely the patient participant's experience of an informal programme run within their ward. Despite the active role assumed by the student participants in the FEHBP, they were not a focus (nor did they form any part) of this research. IPA is flexible with regard to the exact methodological procedure used - usually basic participant information (such as biographical information), as well as more descriptive information (required to contextually situate each participant to the reader) is presented in a table or brief narrative format (Smith, 2004). Although for the purposes of identification an account will be provided in order to acquaint the reader with each participant, the account will only include details provided to the researcher by the participants themselves. A decision was taken at the onset of this research not to consult any records (including hospital files or staff) about any of the participants. The rationale underlying this decision is outlined below.

This research was based on a programme which was largely considered to be a social activity. When this point is combined with the core goal of this research (as in line with the IPA methodology), to find out how participants make sense of their "personal and social worlds" in relation to the FEHBP (Smith & Osborn, 2003, p. 55) it was not seen as necessary to access official forensic or hospital records, outside of the participant's accounts. A decision was thus made by the researcher to use only information obtained from the participants themselves. The decision taken by the researcher not to access official patient files, does not negate the fact that she, in her position as intern clinical psychologist, would have access to them had she so chosen. Furthermore, as referred to earlier in the discussion of dual roles, and in line with IPA methodology and epistemology; to obtain a purely objective account of another (or their experiences) is not possible or necessarily desired, as each step of the research process is considered as an interpretative process (Smith, 2004). Thus, while every effort was made to stay as close to the participant's original account as possible (in order to gain a better understanding of their experience), the interpretive role of the researcher (along with her experience within the clinical domain and the various lenses that may accompany this) cannot be disregarded in the research process.

As noted elsewhere within this document, the concept of agency is not something traditionally associated with the clinically-orientated environment (Newnham & Page, 2010) and institutionalised psychiatric patients are largely considered voiceless and as lacking agency (Estroff, 1991, 2004). However, partly as a result of deinstitutionalisation, there is

increasing movement towards a greater emphasis being placed on the individual (Newnham & Page, 2010). It was felt that it was pertinent to hold true to the concepts of individual outcome and agency with regard to the material collection and reporting processes. Therefore, in relation to accounts used to situate the participant to the reader it was felt that the account provided of them by each participant was the one most true and relevant to them, and thus the one that was most potentially illuminating to the audience.

As attempts were made by the researcher to attract a relatively homogenous sample, the participants shared certain characteristics and features. These are outlined in the table below, followed by a brief account of the distinguishing features of each participant.

Table outlining Research Participants

Participant	Account/Narrative
<i>Shared Characteristics</i>	<ul style="list-style-type: none"> - Male, under 40 years old, from the Eastern Cape Province, South Africa. - Disadvantaged backgrounds (low education levels, unemployment, poor support structures, substance abuse and dependence, poverty, crime) - Substance abuse and dependence (marijuana, alcohol, nicotine) - Mental illness and direct involvement in crime (as evidenced by their forensic psychiatric patient statuses) - Currently stable on treatment regime - Resident in a forensic psychiatric ward at Fort England Hospital - Difficulties with successful rehabilitation (attributed to unavailability of custodian or substance abuse) - Active participation in the FEHBP (for a period longer than 1 year; a willingness to engage in interviews)
<i>Participant P1</i>	<p>Prior to admission as a forensic psychiatric hospital, P1 described a relatively unstructured life. A normal day used to consist predominantly of begging, informal odd jobs and street gambling. P1 made several references to breakdown in family relationships (with the exception of one brother, who forgave him for stabbing him during an argument). P1 described stabbing a further three of his siblings. References to mental illness were in relation to current difficulties experienced with regard to treatment side effects.</p> <p>According to his account, P1 is currently awaiting reclassification documents which may involve a transfer to another psychiatric institution outside of FEH. P1 experienced problems in obtaining a custodian due to having to return to the area in which he committed a crime against his mother. He reports that he prefers spending time alone generally, and that he does not have friends in the ward currently.</p>
<i>Participant P2</i>	

	<p>P2 generally described himself as a gangster and as always being the leader of the pack. He identified strongly with rap music stars and spoke with fond memories of times spent figuring out ways to make enough money for fancy clothes and attracting women.</p> <p>He reports living with his grandmother until the age of fourteen, thereafter he became involved with friends that influenced him into a way of drugs and crime (theft and drug dealing). His involvement with drugs and crime intensified when he was sent to a correctional boarding school.</p> <p>P1 described dealing and using Mandrax and Ecstasy on a regular basis, as well as being frequently in and out of prison. According to his account P1 used to go on LOA's; however, he has not been on any recently due to his custodian passing away.</p>
<p><i>Participant P3:</i></p>	<p>Prior to his admission to prison (and subsequently a forensic psychiatric ward), P3 used to live with his mother. Although he used to participate in frequent substance use (including Mandrax), paid for through petty crime; P3 reported that he would attempt to maintain the relationship with his mother by doing odd chores. He referred frequently to his mental illness during the interviews and recalled the effects of what appeared to be his index episode of psychosis, when he stabbed and killed his mother. He recalled this period in his life with what appeared as much confusion, sadness and regret.</p> <p>While he describes having an aunt as his custodian that is supportive of him and recognises his lack of accountability in that instance due to mental illness; he appears simultaneously fearful of the pressure placed on him from his friends to partake in substances and crime during LOA.</p> <p>It is for this reason that he is planning to stay in a halfway house, where he will use the money from his disability grant to pay for it, while also having some money spare to give to his aunt each month.</p>

iii) Sampling

For recruitment purposes, the researcher spoke to a group of potential participants in the ward common room, outlining what their participation and informed consent would entail. Please see appendix 1 for further details. Once individuals expressed interest in participation, separate interview appointments were arranged with three participants. Informed consent, as well as permission to record the interview was obtained prior to the interviews commencing. In this study a purposive sampling method was used to obtain a fairly homogenous sample of forensic psychiatric patients from a particular ward, who were deemed by the multidisciplinary ward team as being not actively mentally ill, capable of supplying informed

consent, who participated in the FEHBP, and who were willing to talk about it in English with the researcher.

As an ideographic discipline, IPA “challenges the traditional linear relationship between the number of participants and value of research” (Flowers, et al., 2005, p. 20). The value lies within the understanding and interpretation of each individual participant experience. IPA seeks to say something specific about the individuals who provide material for the study, and the intent is therefore not an aim for generalizability of results in the traditional positivist sense (Smith, et al., 2004). This is reiterated in the critique of nomothetic psychology by Smith, et al. (2004, p. 42) “as only allowing actuarial or group level claims”. Instead of large groups used for purposes of generalizability, small sample groups are used in order to achieve the detail of experience and interpretation required by IPA. In fact, Smith (2004) maintains that it is possible to extend the ideographic logic to conducting an IPA analysis to a single participant. IPA employs a case by case style in which each participant is provided with the sole attention of the researcher before the next participant material is attended to and joint themes eventually emerge. Smith and Osborn’s (2003) suggestion of three research participants for researchers new to the IPA approach was followed.

In relation to participant recruitment, no incentives were offered for participation. Eligibility criteria attempted to ensure a homogenous sample as outlined by Smith and Osborne (2003). Included in the criteria was that the patient form part of the forensic, long-term psychiatric ward of the FEHBP. The participant needed to have taken part in the FEHBP to the extent that he felt familiar enough with its process to be comfortable speaking about it. As mentioned previously, the physical and mental state of each participant is monitored on a round-the-clock basis by a multidisciplinary staff team at FEH. Thus, a further requirement for participation was that each individual be considered physically and mentally well enough to participate in the research, as well as to provide their informed consent to do so.

Language and Expression

A further requirement was that the participant be able to converse in English (the language of the interviews). Some leeway was available for limited amounts of Afrikaans due to the researcher’s functional/semi-fluency in conversing in it. Interestingly, while it is acknowledged that Afrikaans may have had some degree of effect during the initial interviews, language did not appear to have as large (if any) an impact during the second set of interviews. At times during the initial interviews, it appeared as if understanding (as well

as expression) on the part of researcher and participants may have been curtailed/impacted upon by speaking Afrikaans. It is felt that the researcher (mistakenly) may have relied too heavily on the participant's assertion that they were comfortable to converse in English, when it appeared that Afrikaans may have been preferable to the participants at times during the initial interviews.

Conversely, this was not the case for the second interviews. The researcher surmised that this could be attributed to the greater level of rapport and ease of conversation that was established during these interviews. Thus, while language may have affected the material collected to some extent, it was not considered to be an area of major concern overall. In addition, when viewed within the greater scheme of the research process, it was felt that the potential impact of language on the material collected during the first interviews was not sufficient to negate or adversely affect the content quality of the material collected. Smith (2004, p. 50) asks: "Do the gains from speaking to this particular group sufficiently outweigh the costs from not speaking the same language?" On reflection of this by the researcher, it was felt that the answer was in the affirmative.

Admittedly, this research might be criticised by some for not employing the services of a translator. Within the field of IPA literature on the topic, in an IPA study of practitioner's experiences of working with language interpreters, Raval and Smith (2003) documented numerous difficulties in working with translators. Included in these were the issues of trust, the difficulty establishing a working alliance, role ambiguity and change, or loss of meaning through translation. It has also been acknowledged by Smith (2004) that when interviewing participants whose first language is not English practitioners should draw on their own professional experience and context to modify interview protocols sufficiently to collect material.

However, this assertion is not without its own complications pertaining to perceived constraints of context. For example, as outlined in the literature review, the Eastern Cape Department of Health is notoriously constrained with regard to financial and human resources. It was felt by the researcher that finding a skilled translator who was available was an extremely challenging task. Additionally, the three participants spoke a colloquial mixture of English, Afrikaans and Isi-Xhosa. Thus finding an English, Afrikaans and Isi-Xhosa speaking translator added further to the difficulty of finding an available translator. Furthermore, in the South African context Drennan, Levett and Swartz (1991) have

documented the complex set of factors affecting the translation process of an Isi-Xhosa version of the Beck Depression Inventory. They found that perceived power differentials in the social, cultural and occupational realms adversely affected the translation process, and went so far as to assert that the “translation enterprise could be seen to be reproducing apartheid structures” (1991, p. 361). For example, it has been noted previously that black nurses in South African psychiatric hospitals are exploited as language and cultural translators for white, English-speaking professional staff (Swartz, 1999).

The forensic context in which the participants reside has relevance, particularly for the second set of interviews. While much of the content of the initial interview schedule related primarily to the participant’s experience of the FEHBP, the interview schedule of the second set of interviews contained questions relating to the participant’s personal life prior to admission, and thus had the potential to induce discussion of the events that led to them entering the forensic psychiatric system. Thus, in addition to the practical issues that could have arisen from working with a translator, it might have served to compromise the participant’s sense of confidentiality, rapport with and trust in the researcher.

iv) Collection of material

Each participant was interviewed twice (for approximately an hour each time) over the course of the research period. The interviews were conducted in two stages, the first in 2012, and the second a year later during 2013. Semi-structured interviews were used, mainly because their flexible nature allowed for novel and unanticipated topics to emerge, and for the researcher to probe areas of interest as they emerged (Smith & Osborn, 2003). It was also felt that the element of flexibility provided broad parameters within which to establish rapport with the participants (Smith & Osborne, 2003).

For the initial interviews, Smith and Osborn’s (2003, pp. 55-64) guidelines on semi-structured interviews were used: specific questions were formulated ahead of the interview around predetermined areas of interest (such as details and understanding of participation, RU student participants, how the FEHBP was experienced, and identity and experiences of self, - please refer to appendix 2 for initial interview schedule). The three interviews ranged in length from 34 minutes to 56 minutes and were conducted in the participants’ ward eating hall, with only the researcher and participant present.

The flexibility and range of material that can be achieved using IPA have been generally acknowledged, and hailed as a strength by some (Smith, 2004; Smith, Flowers & Larkin, 2009; Willig, 2007). But others have criticised the level of analysis in some published IPA studies as lacking in depth (Brocki & Wearden, 2006), and relying too heavily on an empathic as opposed to a questioning hermeneutic that effectively employs interpretative or interrogative principles (Larkin et al., 2006; Smith & Osborn, 2003). It was felt that the material obtained from the initial material collection process was situated too decisively in the latter category to stand independently. In other words, the interviews were judged as being limited to a mere 'first-order' analysis; "one which summarises participants' concerns, but does not develop further to an interpretative or conceptual level" (Larkin et al., 2006, p. 103). The material that emerged was largely descriptive, outlining basic information about activities within the FEHBP, along with some anecdotal (although relatively superficial) accounts and reminisces of interaction between the patient and student participants.

On reflection, the lack of depth achieved in the first set of interviews was attributed to multiple factors. The researcher's lack of experience in interviewing within a clinical environment was one such factor: it was felt, for instance, that questions were frequently structured inappropriately to elicit sufficiently detailed responses (closed versus open forms of questioning, leading questions, overtly thematic questions). Additionally, the researcher's lack of confidence within a clinical environment manifested in what appeared to be apprehension and anxiety relating to silences. This resulted in minimal spontaneous engagement and interaction with the topic at hand by the researcher and the participants, leaving readers of the interviews with a sense of not really knowing the participants, or with sufficient insight into what their experience of the FEHBP may really have been like.

Second Set of Interviews

It was decided to attempt second interviews with the original participants in order to clarify and augment the material already obtained. The original participants were approached, and they consented to participate in an additional interview. Interview appointments were made, and once again, informed consent and permission to record was obtained from each participant prior to the commencement of interviewing.

Seidman's (1991) detailed guidelines for phenomenological-based interviewing were used, as it was felt that they were simple yet explicit enough usefully to guide the researcher in eliciting more in-depth material from the participants. Seidman's approach to interviewing

was deemed suitable as one of its underlying presuppositions is that “people’s behaviour becomes meaningful and understandable when placed in the context of their lives and the lives of those around them” (Seidman, 1991, p. 10). This appeared to resonate with the IPA approach. Obtaining further information relating to the participants’ lives would assist in contextualising (and thus adding depth to) material that emerged from the first interviews, as well as potentially providing a foundation for giving the reader access to their actual experiences – another key point of IPA (Smith & Osborne, 2003). An attempt was thus made to structure the second interviews in such a way as to elicit information regarding the participants’ lives before admission to FEH so as better to situate, contextualise (and thus shed further light on) their experience of FEHBP. Seidman’s (1991) interviewing guidelines seemed appropriately positioned to assist the interviewer in obtaining enough agency to balance the double hermeneutic required in IPA (Smith, 2004).

Despite a suggested ideal scenario of three by ninety-minute interviews spaced between three days and a week apart, Seidman (1991, p. 15) concedes that “as long as a structure is maintained that allows participants to reconstruct their experience within the context of their lives, alterations to the three-interview structure and the duration and spacing of each interview can certainly be explored”. After due consideration of the time available, it was decided that single hour-long interviews with each participant would be scheduled approximately a month apart in order to allow time for transcription. A flexible, open-ended interview schedule was created beforehand (please refer to appendix 3). Once the interviews were transcribed, a copy was provided to each participant to give them the opportunity for feedback or elaboration.

Reflection on interview process

Initially the lack of depth obtained in the initial interviews was perceived by the researcher as a setback. However, on reflection, it became apparent that the process of reviewing each initial interview transcript (as well as the themes and subthemes that emerged during the initial material collection and analysis) was in keeping with the ideographic nature of IPA research as outlined by Smith and Osborne (2003). It also allowed the researcher to confer with supervisors regarding future interview content and direction so as to improve the quality of the material. The second set of interviews would provide a further opportunity for the participants to clarify or elaborate on their responses.

From a retrospective viewpoint, and regardless of the time it took to do so, making active use of the interpretative/interrogative principles within IPA (probing, questioning) appeared to have helped ensure that the final account that emerged was as close to the participant's actual, 'full' experience as possible within the context. Similarly, employing this flexible, back-and-forth approach in part fulfilled the iterative expectation of IPA, that the researcher "in real-time, is in a position to follow up on interesting and important issues" (Smith, 2004, p. 50). This last point was especially apparent to the researcher within the second set of interviews, due to the level of familiarity achieved with the initial material at that stage.

Various methodological and practical considerations arose from the experience of engaging in the first set of interviews. For example, a conscious attempt was made by the interviewer to use more open-ended questions: thus questions such as 'tell me three things you enjoyed' were replaced with 'how did you find it?' in the second set of interviews. Additionally, attempts were made by the researcher to provide less leading definitive responses to the participant and to keep quiet more, in the hope of encouraging further detailed and rich engagement from the participants, in other words, to make sure that what emerged were the participant's own thoughts and feelings, rather than those led by the researcher.

v) Analysis of material

The inductive principle refers to the flexible way in which theory is produced from the material collected; that is, the subjective individual accounts. A bottom up approach is favoured in which there is "no attempt to test a predetermined hypothesis of the researcher" (Smith & Osborn, 2003, p. 55). For example, in the case of this research, the social support theory was posited as a tentative way of describing how non-professional interventions might work. As the themes emerged, an inductive process allowed for this tentative hypothesis to be explored from various different angles.

Interpretation is achieved through an iterative procedure of the researcher documenting his/her "interpretive commentary and using verbatim examples for illustration and support" (Flowers, et al., 2005, p. 22). The analytic procedure is iterative in that it is a process of interpretation (through transcribing, organising and coding) rather than a single interpretation. Thus, the researcher continually refines his/her interpretations in order to allow particular topics to emerge, which are then refined further into themes and sub-themes that best

describe the researcher's interpretation of the participant's experience (Smith & Osborn, 2003). Eatough and Smith (2007) capture the analytic stages of process as follows, which is applied successively and accumulatively to the transcript/s of each participant:

- Several close and detailed readings and initial annotations of the transcribed material to gather a holistic view that is specifically and carefully grounded in the participants' accounts
- Initial themes are identified, which are organized into thematic clusters, grounded in the material
- Themes are then "refined, condensed and examined for connections between them"
- A narrative account is produced of the "interplay between the interpretative activity of the researcher and the participants' accounts of their own experiences". (p. 45)

Smith (2004) asserts that there are different levels of interpretation, with some levels requiring further interrogation in order to reach the deeper levels of interpretation required by IPA. For example, one requirement of an in-depth IPA analysis is that it "makes a contribution to psychology through interrogating or illuminating existing research" (Smith, 2004, p. 43). Interpretation and interrogation of interpretation are required to extend beyond the interpretive analysis of a participant's experience, to a positioning within, or in relation to "wider social, cultural and perhaps even theoretical contexts" (Larkin, et al., 2006, p. 104). Interpretation therefore in the sense that Smith (2004) implies (as well as the active role of the researcher in the interpretation of experience), is argued to be a crucial component of IPA research.

vi) Validity, Reliability and Ethical Considerations

Validity and Reliability

In addition to the methodological rigour outlined in Smith and Osborn's (2003) IPA and interview guidelines, Elliott, Fischer and Rennie's (1999, pp. 215-229) guidelines for establishing rigour in qualitative research were used. Procedures that were incorporated included contextually situating the sample in order to "aid the reader in judging the range of persons and situations to which the findings might be relevant" (Elliott, et al., 1999, p. 222) as well as the grounding of material in examples that illustrate how themes were derived in order to make apparent the fit between the material and the research conclusion (Elliot, et al.,

1999). A credibility check, in the form of a supervisor's advice and expertise, was present throughout the analysis. As the "main currency of an IPA study is the meanings that particular experiences, events and states hold for participants" (Smith, 2003, p. 53), the transcripts were provided to each participant, along with the invitation to provide feedback (Macran, Stiles & Smith, 1999).

Ethical Considerations

In the management of involuntarily committed psychiatric patients, a balancing act of the ethical principles of autonomy (safety and rights of patient) and custodial care (care of patient individually and in relation to society) are required (Moosa & Jeenah, 2008; Van Staden, 2007). This balancing act extends to clinical practice and management, as well as to research. In the case of involuntary patient treatment and care (and perhaps even more so to those within the forensic category), custodial care tends to supersede autonomy (Moosa & Jeenah, 2008). As a core influence, the ethical principle of custodial care contributes to involuntary forensic inpatients (such as the participants in this research) being categorised as part of a vulnerable population.

It has been well documented that vulnerable populations such as forensic psychiatric inpatients are under-represented in research (Baker, 2000, p. 95; Thibeault, et al., 2010). In commenting on the under-representation of vulnerable populations in research and scientific literature, Moore and Miller (1999 cited in Hayes, 2006) suggest that challenges associated with research protocols with vulnerable populations may account for this gap. They include the illustrations of fear of gaining access to the population or disapproval from institutional review boards as examples (Moore & Miller, 1999 cited in Hayes, 2006).

The arguments detailing under-representation of this population sector in research is countered with the view that extra caution needs to be applied with research with vulnerable populations due to their risk for exploitation. Individuals with psychiatric disorders are regarded as being potentially vulnerable to exploitation not just in relation to capacity to provide informed consent, but also their "susceptibility to coercion as a result of the power differential between the investigator and the potential participant" (Yanos, Stanley, & Greene, 2009, p. 376). In other words, as far as is possible, careful consideration is required from the researcher to ensure that their position of power in relation to the participant and relative to whatever multiple roles are incorporated (professional, cultural, racial) is not misdirected, even unconsciously, towards coercion of the research participants (Yanos, et al.,

2009). In addition to being involuntarily hospitalised patients, there is also the forensic aspect to take into consideration in the power dynamics as it has been noted that those who reside in correctional settings are the most vulnerable of all incarcerated population groups (Peternelj-Taylor, 2005).

Because of these considerations, this research was thus categorised as ‘code red’ by the Rhodes Ethics Committee criteria. In addition to questions raised about beneficence on the part of participants, vulnerability in this instance refers to the population’s openness to manipulation due to the custodial care requirements under which they are categorised. This means that gatekeepers (such as FEH) legally make decisions for them, and thus issues of informed consent and capacity are brought to the fore.

In line with South Africa’s Mental Health Care Act (2002), a functional approach to obtaining informed consent is preferred (Van Staden, 2007). Essentially, a functional approach requires that a patient’s capacity for informed consent to participation in research is assessed clinically. A functional approach requires that the clinician or researcher, (or as is the case at FEH, the multi-disciplinary team) assumes responsibility for assessing whether a patient can understand what he is consenting to, can actively choose to participate, and is capable of communicating his decision for or against participation (Van Staden, 2007). A functional approach “derives its strength from the sophistication of both clinical expertise and ethical theory, whereby patient autonomy is protected without precluding ethically sound ways of protecting involuntarily admitted patients from exploitation” (Van Staden, 2007, p. 12).

Due to the fact that the participants in this study are involuntarily institutionalized forensic psychiatric patients, FEH is technically the legal custodian of each patient participant in this research. As custodian, legally FEH is mandated to provide consent on behalf of each patient (in line with the principles of custodial care). Despite this, it is the practice of FEH to recognise the individual agency of each patient by obtaining individual informed consent from each patient (in line with the ethical principle of autonomy), while simultaneously ascertaining and ensuring that each patient is capable of doing so. This was accomplished on an on-going basis through weekly ward rounds involving a multi-disciplinary team and through 24 hour observation by the psychiatric nursing team.

In addition the voluntary nature of participation was continuously stressed throughout the duration of the recruitment and research process. A thorough explanation of what the term

‘voluntary’ means was provided during the recruitment process, and was referred to throughout the research process. Related to the voluntary nature of participation was the participant’s right to privacy. Each individual was assured that they could choose whether to share certain information or refuse to answer particular questions.

The element of education regarding what would be entailed in participation (such as the aspect of voluntary participation) was in line with research that provided the recommendation of an educational intervention as part of the informed consent process in order to minimise the effects of reduced capacity (Benatar, 2002; Carpenter, et al., 2000). For example, research by Carpenter, et al. (2000) conducted on 30 American research subjects with schizophrenia found that reduced capacity (particularly illness-related cognitive decline) could be remediated with (and compensated by) an educational intervention as part of the informed consent process. While the effect of this is not tested in the South African context, specifically in relation to the generally low education levels left over from the apartheid legacy, it would certainly be an interesting and useful area for future research. In the instance of this research, information required for informed consent was repeated at the beginning of each interview and participants were provided with opportunities at the beginning, during, as well as at the end of each interview to ask questions.

In addition to an educational component, Benatar (2002) proposed a more involved and inclusive role for research ethics committees. Permission to conduct this research was sought and obtained from several gatekeepers and ethics committees. These included Fort England Hospital; the Rhodes University Ethical Standards Committee (RUESC) (oversees the process of all research applications and attempts to ensure as far as possible that research is carried out according to internationally accepted ethical standards); and the Rhodes University Psychology Department Research Projects Ethics Review Committee (RPERC) (acts on behalf of the RUESC to review all ethical aspects of research proposals submitted to it).

Furthermore, the ethical principles of beneficence and malevolence which underlie the practice of psychology (Allan & Love, 2010) were used as further safeguards throughout the research process. In the context of research, beneficence refers to clinicians maintaining the welfare of their participants as central to their research process (Allan, 1997). Similarly, non-maleficence refers to avoiding harm caused to participants as a result of the research process (Allan, 1997).

Regarding the principle of non-maleficence, it is argued that a small safeguard of this research was that overall it did not seek to explore 'sensitive' experiences. The primary aim was to explore personal experiences in relation to a programme that was intended to benefit participants through the provision of external support and companionship. However, it is acknowledged that material gained from the second set of interviews, relating to the context of participants did contain information relating to experiences that were considered 'sensitive' (such as substance use, violence, murder and breakdown of relationships).

Although information of this nature was not asked for directly by the interviewer, it emerged nevertheless. Once again dual roles came into play here, as it was felt that the researcher's alternate role of intern clinical psychologist would provide her with the skills to gauge when to stop asking questions of the participant, or to move away from a subject that appeared to be upsetting to the participant, or to offer additional help in the form of the services of the ward therapist. Additionally, the interviews were conducted in a multi-skilled psychiatric hospital, with experienced psychologists, psychiatrists, nursing and security staff. It was the ideal environment to contain any potentially negative/harmful situation to participants or researcher should that unfortunate scenario have arisen.

However, the power dynamics that may have been present in relation to roles (Yanos, et al., 2009), for example between patient and 'outsider' or 'researcher' or 'professional', and which possibly may have contributed to a sense of coercion, had to be borne in mind. An attempt was made by the researcher to remain aware of the power dynamics that might be at play and to be conscious of not exploiting these dynamics within the relationship. Thus, the researcher checked in regularly with the participants throughout the interviews, asking if they were comfortable, or asking for permission to talk about particular topics and respecting participant's wishes not to continue with particular areas of conversation. In addition to this, copies of the transcripts were provided to each participant by the researcher personally, which was used as a further opportunity to check in with them. As far as possible, no part of the research process was conducted in the immediate presence of FEH ward staff. This was in order to ensure confidentiality, as well as to alleviate the potential risk of participation being perceived as having any potential consequences in relation to treatment within the wards – thus viewed as a potentially unintended or external form of a coercive nature.

Regarding the principle of beneficence, it might be argued that the act of participating in this research may in itself have held benefits for each participant. For example, Widon and Czaja

(2005) found that American psychologically vulnerable, incarcerated, black research participants benefitted most from inclusion in research, and believed in turn their research contribution to be important due to their typical experience of non-inclusion and non-participation. Despite the differences that may exist with regard to nationality and culture between the research participants and those in Widon and Czaja's (2005) sample, their findings might be relevance for this research, as patients involved in the FEHBP are marginalised on numerous levels: chronic, long-term psychiatric patients, forensic patient status and a low socio-economic status within society. Lastly, the information obtained from participant's experience of the FEHBP may inadvertently provide ways to improve the programme and include more aspects which the participants find positive and beneficial.

Analysis of themes

Table of Analysis

Domains	Superordinate Themes	Themes	Participants' Words
A. Participant Context			
	1) Life on the outside	1.1) Disadvantaged backgrounds	<i>And ya, that's what a normal day was like</i>
		1.2) Substances	<i>It's a feeling where you feel high</i>
		1.3) Crime	<i>Tsotsi-minded things</i>
		1.4) Mental Illness	<i>And then I hear a voice</i>
		1.5) Support structures	<i>I come home alone and there is nobody there</i>
	2) Life on the inside	2.1) The comfort/boredom dichotomy	<i>They never worried because they are always inside, versus, bored in the ward</i>
		2.2) Hospital relationships	<i>They are just doing their job</i>
B. FEH Buddy Programme	3) Description of FEHBP	3.1) Participation	<i>I am always in it</i>
		3.2) Activities	<i>Yes, you gonna play with us today!</i>
	4) Outcome	4.1) Substitution	<i>We don't use drugs here</i>
		4.2) Experience	<i>They come to let us ease our minds</i>
		4.3) Relationship with students	<i>Down for anything like</i>

The table of analysis is divided into two domains, participant context and the FEH Buddy Programme. Participant context consists of two superordinate themes which outline participant accounts of life outside of and inside FEH. A final superordinate theme then outlines participant experiences of the FEHBP. The rationale behind placing the domains in this order is to provide the reader with a context within which to understand the participant's experience of the FEHBP as a greater understanding of where the participants have come from and where they are currently,

will provide a stronger position from which to interpret and build on their experiences of the student programme.

A. Participant Context

1) Life on the outside

This section provides an account of the participant's experience of their lives outside of FEH. This includes accounts of their lives prior to entry into the forensic psychiatric system, as well as their experiences of leave from FEH, during and in relation to, LOA. The themes are grouped together in a narrative order. The initial three themes are grouped together due to their content references to socio-economic issues, disadvantaged backgrounds, substances, crime. The following two themes, mental illness and support structures, are situated together due to their links with socio-psychological content.

1.1) Disadvantaged Backgrounds

When asked to describe an average day in their lives prior to admission to FEH, all of the participants provided accounts which highlighted the disadvantaged backgrounds from which they originated. Accounts consisted of numerous illustrations of poverty, unemployment, lack of or low education levels, crime, substance abuse and inadequate support structures.

Extract 1

P1: There, every day when I woke up in the morning, I wash my face and my body – my upper body. Never minded about washing my feet

J: {Laughs}

P1: {Laughs} Sometimes I wash my feet also! Then I go to the shops.

Maybe I go into the house first and ask for money, maybe a 50c or R2. And then I go to the shop and buy some cigarettes and chips, and then I eat the chips first and then I smoke. When I finish, then I go home and eat my breakfast...

J: Ya...

P1: And then during the day I used to smoke a lot of ganja. Then maybe I ask again for maybe another 50c, for an after meal cigarette you see.

{Laughs} And then I go to the shop and I get to the shop and then I stand there by the shop and I smoke my cigarette. And people going to work, I used to ask them for money. I ask money from them and they give maybe another 50c, or R1 or R2 or R5. And people that come from town, I used to help them with their groceries, help them with getting their bags to their home. And then, they used to give me R5. And then I take that money and I use it for gambling....

In extract 1 the participant describes an average day in his life prior to admission to hospital. The reference to washing only the upper body alludes to washing out of a bucket and thus, the absence of basic bathroom equipment such as a shower or a bath that would be otherwise commonplace in formal accommodation such as a house. There is no mention made of family or other conventional or formal support structures. There is a general sense of deprivation in the account.

The extract highlights the lack of formal or gainful employment, which characterised the accounts of all three participants. There is a sense of a hand-to-mouth existence, where life is lived on a minute-to-minute, day-to-day basis, obtaining money for modest requirements such as chips or loose cigarettes. What money is gained from begging is used for gambling, thus offering no sustainable momentum to potentially change the status quo of lack of access to money.

Smoking cigarettes punctuates the account and appears to be set into the daily routine of the individual, as was the case for the other participants as well. Smoking cannabis is referred to as a common place activity, as casually and as often as one might expect someone to refer to a mundane but necessary task such as brushing their teeth. The sense that smoking cannabis was accepted as the norm came across strongly in all participant accounts.

Extract 2

P2: [laughs]!!!! You see, a person inside, he will never like to waste. [laughs]
Whatever it is, he won't waste it. ... People outside, they waste a lot.

J: What do you mean?

P2: Like, tobacco for instance... You can get a person outside, his tobacco will fall outside, and he will not pick it up.

J: Ya?

P2: [laughs] ...but a guy's tobacco will fall out and he will pick up each and every last piece of it [laughs] and put it back! [laughs] ...ya[laughs] ... yaaaaa!

Extract 2 highlights once again the place of importance that tobacco has in the lives of the participants, with frequent references made to it forming part of their daily routine. The reference to not wasting implies a continued felt sense of deprivation within hospital life, where wasting a scarce commodity such as tobacco is considered unheard of. The sense of deprivation appears to be continued into the post admission lives of the participants from their lives prior to admission. Additionally, it draws attention to the perceived clear

distinction between people 'inside' (hospitalised/incarcerated) and those 'outside' (free citizens).

1.2) Substances

All three of the participants made frequent references to smoking marijuana several times a day prior to their admission to hospital. In their accounts, it appeared as if the participants had begun smoking while in their pre-teenage or very early teenage years and that this was considered to be the norm within the communities in which they lived. It would seem from their accounts that smoking marijuana formed a significant part of their daily routines, as well as their sense of selves. The consumption and abuse of alcohol was also mentioned by each participant as a commonplace activity. All three participants appeared to be dependent on nicotine. Two out of the three participants admitted to engaging in the use of mandrax, with one adding to the list drugs such as ecstasy on a regular at least weekly basis. All of the participants made direct references to spending any financial windfalls on substances.

Extract 3

P2: Mmmm, maybe you will find it strange, but I enjoy most my time smoking weed ...[laughs] ...

P2: See the first time when I smoked, uh, I was laughing a lot, eating a lot ... and it, it was as if when I was walking in slow motion ... and everything ... everything was just slow around me ... and ya, that's how it was.

In extract 3 the participant describes his experience of being high on marijuana (weed). He openly admits that it is his favourite way to spend his time. It appears as if the participant experienced a sense of detachment from the environment around him when high, and that he found this experience to be pleasing and desirable. The sense of enjoyment, having a good time and freedom from worries while high were sentiments expressed by all three of the participants. A clear sense of either numbing or escapism was apparent in their accounts of their drug use.

Extract 4

P3: It was bad for me. Why, because it's my mother ... and I don't know what, maybe someone will do something wrong to me, do wrong things. And I go to jail. And that other guy there, he roll up a dagga zol there. And I smoke too, though I don't want to smoke, but something say to me that I have to smoke. I smoke once.

In extract 4 the participant describes being in prison following his arrest for the murder of his mother. It would seem from his full account that he appeared to be actively mentally ill during this time. He describes his continued distress over the realisation that he killed his mother, as well as his fear of reprisal from community members. It is unclear whether the ‘something’ that compelled him to smoke was his need for a way to escape from or cope with his mental and psychological torment, or if it was a hallucination symptomatic of mental illness – either are reasonable interpretations to assume.

Extract 5

P3: I leaved the school in standard 5, grade 7. After school, I smoked guanja with my friends... I drink alcohol with my friends. And then after that, we broke up, and I go to other friends, I get other friends...and then, those friends look only for money. Robbing people, break houses in, and we go to (PLACE) and rip the people there. And we go into jail and out of jail ... and Do the same thing ... like that ... sad.

In extract 5 the participant highlights the early age at which substance use, in the form of alcohol and marijuana, began for him. Substances appear to mark a turning point within his life towards criminality. This sentiment was echoed in the accounts of the other participants. As a shared activity with friends, the pervasiveness and acceptance of substance use (as well as early age of onset) is brought to the reader’s attention. Thus, in this instance, substance use appears again as a type of sub-culture, influencing those who move within it.

Additionally, this brief extract provides the sense that it appears as if substance use, for this participant, provided a gateway into other categories of sub-cultures, such as crime. His acknowledgement that the negative self-perpetuating cycle of crime and jail time is ‘sad’ reflects a level of insight into the links he appears to have associated with the pattern of substances and crime within his life.

Extract 6

P3: I don’t want to use the alcohol and substances with treatment ... And they say, “But...no man, you’re alright, Mr. Cool” and I say, “No, but it’s alright, I’m going to stay by home”. Then I stay there and I think by myself that there’s nothing to do. I get home. And I got money then. I think now I’m going to take a drug now, then, a drug ... laughs ...

Extract 6 illustrates the ongoing difficulties that the use of substances plays with regard to rehabilitation of forensic psychiatric patients. In addition to the consumption of alcohol, abstaining from all illegal substances is a condition of LOA. Should a patient granted LOA consume substances while on leave, upon his return to FEH he will be demoted within the behavioural modification programme (BMP), and have to work his way up to the top group which allows for LOA privileges to be granted. It is thus understandable that this delays the potential rehabilitation process.

In the extract, the participant describes his experience during one of the leave of absences (LOAs) in which he consumed substances. The opening line of the extract shows his awareness that substances should not be used in conjunction with medication for the treatment of mental illness. His initial desire to conform to an LOA requirement of remaining sober is superseded by his need to escape the sense of boredom he experiences in his home environment. The role of substance addiction and dependence is also provided as a possible explanation for his decision to return to substance use.

1.3) Crime

The participants provided many references to the pervasiveness of crime within their lives. As forensic psychiatric patients, all three had come into personal contact with the legal system prior to their admission to a forensic ward at Fort England Hospital.

Extract 7

P2: I meant that, at the time ...I was, uh, I was...just, that I couldn't listen anymore to ... to ...the things that were right ... you know? ... I could listen, but ...I couldn't, I couldn't do it ... you know, because my friends ... they were, I was, into this nigger music, this gangster music, the gangster rap. So we were living our lifestyles that ways. ...

In extract 7, the participant voices his perception relating to the pervasiveness of crime – almost as if it was an eventuality that was certain to happen and that he was destined to succumb to. He uses ‘gangster rap’ almost as a metaphor for crime. The reference made to the involvement of his friends hints at crime not just as something that occurs or is actioned; but as a type of culture or sub-culture, to which he (and his friends) belongs to.

Extract 8

P1: He stabbed me here. He stabbed me in the mouth and stabbed my teeth out. And then I run. I run up to my friends and I took a bottle and I break it. And I go back to him, and again, he stabs me in the head!! {LAUGHS}
J: Ya ...

P1: And I also stab him, but the bottle didn't go the whole right way through, you check? {LAUGHS} And then I said, "no, sorry broer {brother}... sorry broer!" {LAUGHS} And then he said, "Okay, come on let's take you to hospital!" {LAUGHS}.

J: So, you guys stabbed one another ... and then became friends and went to the hospital together?

P1: {LAUGHS} Ya! {LAUGHS}

In extract 8 the participant describes an incident where he and his brother were drinking alcohol together and then began to argue. He does not mention what started the disagreement. The context of the extract was with his favourite brother – the only sibling (by his own account) that 'still loves him', and who he loves. This participant made references elsewhere in the text to incidents where he had stabbed three additional siblings (a brother and two sisters), which resulted in the deterioration of their relationship.

Both the participant's and his brother's apparent acceptance that stabbing one another was just one of those things which happens when one argues provides an indication as to the pervasiveness of violence, making it appear almost routine. Just as commonplace, it would seem is the apparent acceptance of, or resignation towards, substance abuse as the norm (more pertinently, to the level where intoxication fuels extreme violence).

1.4) Mental Illness

In the case of forensic psychiatric patients, mental illness is an issue that is unequivocally linked to crime – they entered the forensic psychiatric system as a result of being found either not fit to participate in court proceedings, or not guilty of their crime by virtue of their mental illness. Although the subject of mental illness was not directly referred to by every participant, the devastating effect on their lives has resulted in their involuntary placement within the forensic psychiatric sector.

Extract 9

P3: And they say to me, "(NAME), what's wrong?" And I say, "no, I don't know, I don't know what's wrong." ... But, the time that I sleep there, I look there by that venster {window} and I see it, but I don't, I didn't tell them people. Because there ... going to come something, something what happened to me... (coughs). And then that Aunty say to me, "[NAME], your mother is dead". I say, "no man, don't lie man, for what?" She say, "no, you steek {stabbed} your mother ek se {I say}". And then here come my brother, he bring for me something. And I see my brother, and my tears run...

In this poignant extract 9, the consequences caused to an individual, as well as his family, by his mental illness is clearly evident. The participant's confusion, shock, fear and sadness over the realisation that he killed his mother are heavily felt within his testimonial.

Extract 10

P3: And I go, and the community comes, and they throw stones. And then here come my friend's mother, and I steek {stab} her with the knife. And I go with the knife and I go and throw stones and they throw me here with a stone. (Shows scar on forehead).

Extract 10 is a continuation of the same participant describing the community's reaction to him on the night that he killed his mother. While his initial account detailed his experience of confusion and vagueness due to mental illness; this account details the community's apparently goal directed and forceful reaction to his observable behaviour on the night. There is a sense of discrepancy and incongruence between the two accounts. In this instance, the point that his actions were as a result of being actively mentally ill appeared either unknown or irrelevant to the community members. Thus, the legal issue of responsibility does not negate nor necessarily prevent the threat of violence towards mentally ill individuals or their family members. This was evidenced in accounts from the participants not just in relation to the short term time frames after the crime, but also with regard to the medium and longer term, where chances of a successful LOA were adversely affected by the perceived threat of continued victimisation or retaliation from community members.

In addition to the devastating effects that mental illness can have on an individual's life, in the case of forensic psychiatric patients where successful rehabilitation is no longer deemed a possibility, it may also result in permanent reclassification to an involuntary psychiatric patient. Even though the participant in extract 11 below initially admitted that the hospital felt like a home to him, he shortly thereafter retracted this admission due to the move that reclassification as a long term involuntary psychiatric patient would entail. Fort England Hospital is not classified as a long term hospital and thus, when attempts at rehabilitation, (through a succession of successful LOA's) fail, patients are moved to long term stay feeder institutions elsewhere in the province. The lack of agency in this decision is illustrated through his admission that he is dependent on the hospital board and its members to make their decision.

Extract 11

P1: No, at four o'clock then we come home, back to the ward ...

J: Is here your home?

P1: {LAUGHS} Yes, it's a home. Ya. Maybe I'm going to die here {LAUGHS} ... but I don't think so...because Doctor [NAME] said that I am going to go to [PLACE – another psychiatric institution]...but I must first see the board, I must first see the board you see...then they can reclassify me and then I can go to [PLACE – tertiary level psychiatric institution].

1.5) Support Structures

Extract 12

P1: Now I was about twenty eight or twenty nine and I used to come home and there was nobody there by the home ... so I used to go to that other pastor's home and say, "Pastor, Pastor, please give me a meal, I am hungry." And then he say, "Wait outside." And then he make me some bread and tea you see. And maybe some rice left-overs from yesterday you see. And then I eat and I eat it...and then I feel my tummy. Then I saw my mother, there she go...Doesn't even look at me...But maybe she doesn't see me, I don't know does she see me...And I am eating there and sitting outside. Every day I used to eat there by the Pastor's house...I wash his car and he give me R15.

In extract 12 above the participant describes how a pastor supported him by providing him with food and occasional paid work. Once again, a sharp sense of deprivation is felt, with poverty and unemployment being key factors at play. That this participant had only the pastor to rely on highlights the lack of alternative support structures such as family and friends available to him. It also highlights the lack of formal support structures such as shelters or aid organisations within his community. None of the participants made reference to any form of official or formalised support structures (for example, such as social work, psychological or psychiatric services) prior to their admission to hospital.

The participant's wondering as to whether or not his mother was purposely ignoring him, as well as the point that he was either unwilling or unable to approach her, show the level of family discord present. It may also infer fallout as a result of behaviour stemming from substance abuse, mental illness or both.

Challenges relating to lack of support structures prior to admission may translate into additional difficulties post admission, particularly with regard to successful rehabilitation

through reincorporation back into the community. For example, a lack of familial or friendship support networks make the task of finding a custodian to take responsibility for the patient while on leave of absence unlikely, if not improbable.

Extract 13

P1: Ya, my sister. My sister said that she is going to try, that she is going to ask for me in December. ... But, at first when I asked her, she wouldn't let me. She said my Mother's case I am responsible for. ... But they said there in the ward round that the case that I did to my mother ... so my mother can't be my custodian.

The participant in the extract 13 committed a crime towards his mother, for which he was found not responsible for by virtue of his mental illness, and thus he entered the forensic psychiatric inpatient system as a state patient. Despite being deemed not responsible in the legal sense for his actions towards his mother, it is nevertheless understandable that there be difficulties associated with him returning to the place where he committed the offence, or to the person for whom the offence was committed against. Finally the brief extract also highlights the sense of dependency of the participant on others – whether it be the state (through the hospital), or to his family (as a possible custodian).

2) Life on the inside

This section provides an account of the participant's experience of their lives since their admission to FEH. Two themes, comfort/boredom dichotomy and hospital relationships, will be presented in the next section.

2.1) The comfort/boredom dichotomy

In extract 14 the participant describes an average day in his life at the hospital. Accounts provided by all three participants were similar in that there was a definite sense of routine, only punctuated by meals, sleep and activities (such as gym, occupational therapy and the FEHBP), smoking cigarettes. Like the accounts from the other participants, there appeared to be little room for surprises or novelty within the daily routine of the participant below – each minute was accounted for, and he appeared aware of exactly what was expected of him. The sense that this strict routine is both boring and comforting comes across strongly in all accounts provided by the participants.

Extract 14

P1: The day ...I always count it all just so, you see. But I can't count how many times I smoke you see. But in the morning, it's wake up. Then I go and smoke a zol in the smoking area if I have. If I don't have, then I wake up and go and wash myself in the shower. After going to the shower I make myself alright with the cream [Mimics putting cream on face]. I put on some cream you see {LAUGHS}. And then I wear my clothes. And then I brush my teeth. And then, after that ...I don't comb my hair because it is still so short! {LAUGHS} Ya, then we, then we smoke there in the smoking area. No, but we smoke outside now, they don't want us to smoke there in the morning [gestures elsewhere]. Then we go for a walkie and we go around the wards, these two wards. Then we come back and we gym. Then we go in and I am a waiter also. After we have pray ... we first pray, ya, we pray ...after praying then we smoke again. Then they call the waiters.

In extract 15, it can be seen from the participant's explanation that boring is not associated with a lack of activities to occupy his time with, but rather, a lack of interest or engagement with the activities he undertakes. The acknowledgement that the car wash job required hard work was also acknowledged in the accounts of the other participants. Despite the car wash being busy, he finds the task of working there hard work and unenjoyable. Thus, it is the quality (rather than the amount/quantity) of activity that is important in establishing/contributing to perceived level of enjoyment or engagement with it.

Extract 15

J: Mmmm....now Tell me, you said that during Occupational therapy that you clean cars and offices ...how is that for you?
P3:No, it's alright, but sometimes there by the car wash is bored.
J: Boring?
P3: Ya, you come there in the morning and you see the cars ...jaw! ... a lot of cars...but, I must wash that car...why, because I will choose the car wash, because often there's no cars there tomorrow morning.
J: Does it get boring when there aren't any cars to wash then?
P3: (laughs) If there's cars, a lot of cars, then you think, "Yaw! I must now wash three or two cars now!" (laughs)
J: (Laughs) ...ok, but how is that boring though?
P3: Yaw, a car is not so nice to wash. It's a load ... you must clean outside, you must vacuum, wash, afdroeg {dry off}, sweep, vacuum, you must polish the tyres, you must clean the windows nicely ... it's a lot of work! (laughs)

In extract 16, the participant refers overtly to the hospital as a place of safety and refuge for him. The context of the extract is within the possibility of a LOA, in which the participant would stay with his aunt. However, due to the crime/s that he committed there prior to his admission to

hospital, the participant was concerned for his safety due to fears of violence from the community. He was also concerned about peer pressure from his friends in the community. The extract illustrates a sense of disconnect between his life prior to hospitalisation and the present, feeling that he no longer belongs to the life outside which he once lived.

Extract 16

- P3: That time, I ... didn't think about my aunty...I hear by the social worker that my aunty want me home....
- J: And how did you feel when you found that out?
- P3: I don't want to go home that time. I wanted to stay here...
- J: Okay, why was that?
- P3: Because I think I got something. I think the people outside were going to hurt me again...that's why I wanted to stay here.
- J: Oh, so it sounds like that in some ways here was a safe place for you?
- P3: Where?
- J: Here.
- P3: Here? ...ya.
- J: And now that you want to go out and live in the halfway house?
- P3: That's a safe place.
- J: That's also a safe place, okay. And, and, what about your friends?
- P3: I don't worry about friends out there.
- J: Why is that?
- P3: Why? Because the friends, if you say no to the friend, then he can take a knife and steek {stab} you all the way through.
- J: So your friends from outside don't feel like safety anymore since you became ill?
- P3: No

2.2) Hospital relationships

In the extracts below (17-18), participants provide their views on their relationships with various staff within the hospital.

Extract 17

- P1: No, they're alright, they're alright sister ... I can't complain ...because they are just doing their job.

Extract 18

- P2: (the nurses) they take care of us. The students, they don't take care of us, ya, they just come and play games, have fun – such things.

In extract 17, the participant's acceptance that staff such as the hospital wards' security guards were 'just doing their jobs' was echoed by the other participants. There appeared to be a general understanding amongst the participants that the security guards were there to

perform a duty, and that this may at times include reporting patients to the nurses for inappropriate behaviour. There was no mention made of any other form of relationship with them and there appeared to be general acceptance of the clear boundaries that existed in relation to them performing their duties. Similarly, as evidenced by extract 18, there appeared to be a simple understanding and acceptance of the role of caring for the patients which the nurses were perceived to fulfil.

More accessible and in-depth detail was obtained from the material regarding the participant's perceived relationships with the doctors and psychologists. In extract 19 below the participant provides an illustration of the role of psychologists in understanding and empathising with their position of perceived boredom within the ward.

Extract 19

P3: Oh, that other psychologist what were here, he, he decide and say, "come, we gonna play, we gonna games", but he didn't mention that the students weren't going to come. Then he ask the other patients do they want to play nice games and he just say, "don't worry, tomorrow we going to play nice games ... do you want to play games?" We say, "yes, we want to play games." (laughs) ...and then here come the students, and they play with us...And [NAME – Psychologist] was bringing them!

J: Ooooh, why do think [NAME – Psychologist] did that?

P3: You see, Mr [NAME – Psychologist] know us, it's bored in the wards.

In extract 20 the participant describes that in his experience, the doctors are always cool, responding to him in a calm and predictable manner. Regardless of what 'awful thing' he perceives that he may have done, nothing ever seems to be too big for the doctors. The participant appears to gain a sense of security and acceptance from the doctors that he either does not experience, or fears that he will not experience, from other people such as community members.

Extract 20

P2: You know ... they ... they as if, if I can say, Doctors, because they, uh, a doctor ... he never or she never like ...something is too big, you know? It's always just, eh, ...you know? ...can you understand what I'm trying to say?

J: So like, do you mean that it is always sort of manageable?

P2: Ya, like...it's always manageable, ya. Because even when a doctor, when you have done the worst thing [laughs] ... even the community will kill you ... [laughs] ... but he will still be cool, or she will still be cool ...[laughs]...ya ...[laughs] ... I don't know where they get that power from, ...[laughs] ...ya.

B. The FEH Buddy Programme

This section provides an account of the participant's experience of the FEHBP. The first superordinate theme, description, is divided up into themes, participation and activities, which provide a general description of the programme and the activities incorporated within it. The second superordinate theme, outcome, provides an indication as to what the participants may have gained from their involvement in the FEHBP. This is divided up into three themes, substitution, experience and relationship with students.

3. Description of FEHBP

3.1.) Participation

Extract 21

P1: They have it twice a week, yes, and I am always in it ... ya, because I love it mos!

Extract 22

P2: Ya, sure they would benefit, but they also have to be free you know, they have to have a free spirit you know, before they would benefit. They shouldn't be, uh, pulled back you know, they should be free. If they are free they are going to have a good time!

As per extract 21, all of the participants reported regular and apparently enthusiastic participation in the FEHBP, never missing a session unless unavoidable. Similarly, the voluntary nature of participation in FEHBP was referred to by all of the participants. The participant in extract 22 showed that he appeared to value the voluntary nature of FEHBP. When asked about the potential participation of other patients in the ward, he stressed that part of the enjoyment associated with FEHBP was each individual's freedom in their decision to participate. This freedom of choice was linked by him to enjoyment.

The only exceptions to participation provided were when FEHBP was not running due to the Rhodes students being on holiday or writing exams, or if the patients were not present at the hospital due to being on LOA or involvement in an activity such as therapy. This can be seen in extracts 23 and 24 below.

Extract 23

P3: Then I'm going to be there by therapy, if I come out of the therapy then he's not here. They were already here and they's gone.

Extract 24

P2: I participated until the students were writing exams ... so then this year I started again, but then went to where I came from, I am actually coming from home now.

Extracts 25 and 26 allude to there being a certain level of anticipation for the student visits, as well as a particular level of disappointment when either not taking place or being finished.

Extract 25

P1: But they come and go and then I feel sad when they go and then they come again and then I'm glad again!

Extract 26

P3: Sometimes I ask my friends, when come that students? Man, jaw! When? No they don't know! I ask the sister when, when the students what play games going to come. No, the students is on Exam leave.

3.2.) *Activities*

When asked about what activities the FEHBP consisted of, all of the participants appeared to provide vague accounts. Although there were references made to various card games (Crazy Eight, Uno), games (Dominoes, Pick Up Sticks) and activities (listening to music, dancing); the participants did not provide much detail in relation to these. This is evidenced by the combination of brief accounts contained in extract 27 below.

Extract 27

P1: No, we never talk about anything, we just play the games.

P2: Having fun and killing time

P3: I like the playing. And then I just like to sit with my partner, my player, and say pick a card (LAUGHS)... I'm the winner in Dominoes! But I like only Dominoes players man, you see, because I am the dominoes player!

As can be seen by extract 28-30 below, the one activity frequently mentioned by all of the participants was laughter.

Extract 28

P1: They laugh with me. They enjoy anything with me. We sit and we laugh and we play cards. We play donkey, we play crazy eights, then we play the whole time!

Extract 29

P3: The students come and give us happiness, things to play games. And say, yes, you gonna play with us today! ... and then we just laugh and play, laugh and play, happy!

Extract 30

P2: Ya, it helps me in a way because, um, many times when we used to sit here, and we are laughing, you know, we are laughing ... and it's just a nice feeling you know.

It was abundantly clear from the accounts of all three participants (extracts 31-33 below) that the perceived physical attractiveness of the young female student participants in FEHBP was a feature that was experienced as most enjoyable to them. From their accounts, it would seem as if gazing on the students was a favoured activity in its own right.

Extract 31

P1: I really like them because they look even pretty in their faces!

Extract 32

P2: There's a mooi lady in this group and she also like to dance you know!

Extract 33

P3: The programme is just basically about games and pretty students and then we play the student games.

4) FEH Buddy Programme outcomes

4.1.) Substitution

There appeared to be an immediately accessible level of insight displayed by all of the participants concerning the limitations or confines of their surroundings in relation to activities or past times they had undertaken during their lives prior to hospital admission. The participant in extract 34 appeared poignantly aware that while he now got excited about playing games with students during FEHBP, he used to fill his free time openly pursuing/engaging with relationships of the opposite sex. Extracts 35 and 36 illustrates that he was also aware that the visiting students reminded him of and (thus in some ways acted as substitutes for) his family or friends from outside of the hospital.

Extract 34

P3: Sometimes outside, there was generally a woman, and you didn't worry about games and about feeling like playing games.

Extract 35

P3: [students remind of ...] ... My people, because it looks like my people from outside who are coming to visit me and making me feel happy.

Extract 36

P3: We don't see people from the outside here! That's why you must play with the people, the people what come from outside!

The account of another participant (extract 37) likened the experience of eating nice food (such as that provided by the students at their annual party) as a substitute for activities such as using illegal substances.

Extract 37

P1: The time is spent, it's a little bit small, but then after that I, I'm not there in the smoking area, but most of them are there in the smoking area ... I feel much better ... For that time that they here, when they here I don't smoke, I play games all of the time. Just games playing!

Finally, there was also the recognition that FEHBP acted as a substitute for another method of substitution frequently employed by all of the participants – that of smoking tobacco. This can be seen in extract 38 below.

Extract 38

P2: We don't use drugs here and we don't use things that illegal here. So the only thing that we do here is eating, we enjoy eating a lot you know!

4.2.) Experience

What their experience of involvement in the FEHBP meant to the participants appeared to receive greater consideration than their descriptions of the activities they did during FEHBP. In extract 39 below, a sense of distraction and temporary relief from worries is imparted to the reader. It would seem from his account that the participant gained a certain amount of perspective from the brief respite from his usual anxieties. In extract 40, the temporary relief that he experienced appeared not to be limited to a retrospective sense (as in after FEHBP), but also in an expectant sense (in anticipation of FEHBP). Thus, it would seem that there was an associated element of comfort or reassurance of some sort experienced in relation to his participation in FEHBP.

Extract 39

P2: They come to, uh, come to let us ease our minds of the troubles and problems in life you see, they come to ease our soul. It also helps me in the sense that uh, that at times maybe I am thinking a lot of things, and then we start playing the games and my mind just go off those things, and I just go with the flow. And later on when I go back to think about those things, I just feel a bit better.

Extract 40

P2: Just the fact that you know the students are coming is coming today then, then you feel like you been better, so ya, there is a difference, a different in the morning, on the days when the students comes.

4.3) Relationship with students

When asked to describe their relationship with the students, each participant provided an account of a 'special student'; or alternatively, readily accessed a memory of a time when the students as a group had made the participant feel special within their individual capacity. This can be seen in extracts 41-43 below.

Extract 41

P1: They say I must sing for them and then I sing for them and we clap hands! ... (laughs) it made me feel a little bit excited, a little bit scared! ... they clapped their hands and they laugh also ... it made me feel happy!

Extract 42

P2: I don't know, I don't know her name, you know. When she, when we are dancing ... ya ... (laughs) ... I feel good about myself, I feel good!

Extract 43

P3: She comes and says, no – you are my partner, you are my partner, Yes!... And I like, whew, you know that lady I play dominoes with, yaw! I need to play dominoes with, yaw! She count the table, she know what card you said! If I say what my card say, then you, you got the last card, I'd say kak man, here's your card. Then she'd say here's your card! (Laughs)

Despite descriptions of feeling special at times, caution needs to be enacted with potentially over attributing more value to (or over-generalising) the student/participant relationship to constructs outside of what is actually felt or perceived by the participants. This is evident in extract 44 below where a participant appears to react defensively in relation to a (perhaps presumptuous) reference made by the interviewer regarding the importance of the effects that his relationship with the students has on his ward life.

Extract 44

J: Are there other ways with the student that you feel important?
P2: ...[laughs][silence]...important? ...[laughs]...important is a big word!
...[laughs] ...let's not take it that far! ... [laughs]
J: [laughs], mmmm okay, so ... what ... what would be a better word?
P2: Feel good
J: Feel good, okay...
P2: Ya....ya.

In the next example (extract 45), a participant draws our attention to the point that the students gain something from their relationship. He describes how he teaches the students the card game Crazy Eights. Far from being a passive witness within FEHBP, he appeared to feel comfortable expressing his wish to play a particular game, and then following through

with the reciprocal act of teaching the student/s how to play it – an experience which he by his own admission, enjoyed immensely.

Extract 45

- J: (laughs)... okay, so you want to, um, teach them other things?
P3: Other games, ya.
J: Is that ...why is that?
P3: Why, because we know the games here, the students don't know the games. We ask them, "You know Crazy Eights?" She say, "no, what is Crazy Eights?" We say, "no, that game; like this, so so ..."
J: How does it feel for you to be able to know the game and to be able to teach it?
P3: Why, because she don't know.
J: ... How does it feel for you being the teacher?
P3: (Laughs) ... Ek's sommer lief to be a teacher {I love being a teacher}. If she don't know how, then I must show her how to play the game.

In extracts 46 and 47 below, the participants describe the students as always smiling, easy going and providing them with fun. It appeared that both participants' expectations of the students comprised mainly of light-hearted fun. In addition, there seemed to be an element of non-judgemental acceptance from the students that appeared to be felt by the participants within their relationship, with one participant even likening the students to doctors due to their apparent ability to stay calm.

Extract 46

- P2: They were down for anything like, but not, you know, not something that is out of the way, something is positive! ... Um, I don't think ...ya, they ... you know the students, you always see a smile on their face. You know ... they ... they as if, if I can say, Doctors,

Extract 47

- P1: They laugh with me. They enjoy anything with me. We sit and we laugh and we play cards. We play donkey, we play crazy eights, then we play the whole time! ... No, they don't think nothing about me! (laughs) I can see it in their faces, they are very nice people!

Despite descriptions of 'special' associations or acceptance from the students, it was clear from the participant accounts in extracts 48 and 49 below that they were aware of the students as being outsiders and visitors. This appeared to bring with it an awareness that they were required to behave in a different way towards the students – to display the manners that one

would reserve for visitors to one's home. The 'manners' were linked by the participant in extract 48 to the guidelines for behaviour set out in the Behavioural Modification Programme run in the ward which enabled privileges such as participation in FEHBP and LOA's.

Extract 48

P1: I must, I must just behave! I must be in the right manner, like I always do because here you must behave to get home. You mustn't swear. You mustn't sodomise. You mustn't do nothing wrong. You mustn't fight. Like that stuff.

Extract 49

P3: If the visitors come there, you must act so (mimes sitting upright).

The acknowledgement that a certain level of behaviour or manners was expected for the students appeared to extend a level further due to surveillance (by security guards and other patients) as a way of ensuring that this was achieved by all. Similarly, there were also fears expressed of being reported for inappropriate behaviour towards students, without intent on the part of the 'offending' patient participant. This can be seen in extracts 50 and 51 below.

Extract 50

P3: I report him. I say, no, there is this guy that don't have manners for the students.

Extract 51

P3: It's club rules in here man, you're just talking to a student and then they think other things and then they report you...I can't just go next to them and ask them a question ... just now I think, I think that he thinks, they go to the office to report me, all the patients, they will go and report me and say it that it was me who spoke to the student like that.

Discussion

Life prior to FEH admission

: *Disadvantaged Backgrounds*

: *The Role of Substance Abuse and Dependence*

Disadvantaged Backgrounds

All of the participants described backgrounds illustrative of the poor socio-economic circumstances in which many South Africans grow up (Skeen, et al., 2009; Flisher, et al., 2007; Flisher & the MHAPP Research Programme Consortium, 2010; Freeman & Pillay, 1997). From the themes produced it is not clear whether elements such as poor social circumstances or substance abuse increased the risk of participants' developing mental health problems (Skeen, et al., 2009), and it would be inappropriate to suggest that this research indicates any sort of causal link between the two. Nevertheless, the above accounts do appear to lend credence to claims that the immensity of these socio-economic and psychosocial challenges confound the already-stressed and largely inadequate mental health resources in South Africa (Botha et al., 2010; Skeen, et al., 2009; Flisher, et al., 2007; Flisher & the MHAPP Research Programme Consortium, 2010; Freeman & Pillay, 1997; Van Wyk, et al., 2010). This is evidenced by two main points, one relating to pre-admission, and the other to post-admission.

Firstly, none of the participants appears to have had contact with mental health services (community based or primary sector) prior to their admission to a forensic psychiatric hospital. From the accounts of these participants, it would appear that their mental illness went undetected and thus untreated until such time as they were misdirected towards the prison system (Davis, et al., 2012) before being referred to the forensic psychiatric system for observation. This obvious gap, pointing to a lack of appropriate services and mental health care professionals in the Eastern Cape Province (Van Wyk, et al., 2010), indirectly illuminates the need for alternate and additional ways of preventing, detecting and coping with mental illness in civil communities. More focused research into the use of community volunteers and supportive programmes (such as youth groups) to fill these gaps must be conducted to identify possible modes of assistance going forward.

The second way in which these factors negatively affect the participants is in relation to prospective rehabilitation. The numerous criteria that complicate and deter or retard the process of discharge of forensic patients (as outlined by Ryba, 2008) are clearly illustrated within the accounts of these participants: risk to the community, the presence of risk factors within the community for relapse or reoffending, and the availability of placements. Additionally, it would appear from their accounts that the process of symptom management and psychoeducation (for example, on treatment compliance and substance abuse) provided to them while in hospital was either ineffectual, disregarded or nullified within the context of their communities during LOA. Practical research into psychoeducation programmes and the factors which confound them in South Africa's unique context is required.

Substance abuse and dependence

A key and recurring subject throughout all sub-themes was that of substance abuse and dependence. This pertained particularly to smoking cannabis and drinking alcohol (the latter less frequently, and subject to the availability of money). All of the participants described smoking cannabis on a daily basis prior to their admission to hospital. Participants described engaging with substances at an early age, setting in motion a sequence of deteriorations in behaviour, diminishing of support structures and worsening mental health. As was the case with difficulties relating to their disadvantaged backgrounds, problems associated with the participants' substance use prior to entry into the forensic psychiatric system appeared to remain and (by their own admission) negatively affect them during periods of LOA. The substance use of the participants was thus identified as an obstruction in and to the rehabilitation process.

While substance abuse is acknowledged as one of the challenges to mental health services in South Africa (Botha, et al., 2010, Van Wyk, et al., 2010), little elaboration of this in relation to the context of rehabilitation of forensic psychiatric patients could be found by the author of this research during the literature review. More research into the role of substances as a potentially confounding factor in the rehabilitation of forensic psychiatric patients might be useful in establishing more effective rehabilitation programmes. For example, it might be beneficial to provide a substance abuse treatment programme to patients as part of LOA requirements.

With regard to forensic psychiatric patients, the effects of cannabis in relation to mental illness cannot be ignored. Although the exact association between (and mechanisms of) onset

of psychotic symptoms and cannabis use is not clear, its use has been found to be associated with increased risk for psychotic disorder (Arseneault, Cannon, Witton, & Murray, 2004; Kuepper, Van Os, Lieb, Wittchen, Hofler, & Henquet, 2011). In addition to this, a ten-year follow-up and cohort study produced in the United Kingdom found that cannabis use “precedes the onset of psychotic symptoms in individuals with no history of psychotic experiences, and that continued use of cannabis might increase the risk for psychotic disorder by impacting on persistence of (normally transitory) psychotic experiences in young people” (Kuepper, et al., 2011, p. 7). These findings have important implications for the participants in this research, especially when one considers the early age at which they began to engage in substance abuse and the likelihood of their continuing to use substances later on in life.

Furthermore, research that examined five studies of cannabis use and adult psychosis concluded that cases of psychotic disorder could be prevented by educating and discouraging vulnerable youths from cannabis use (Arseneault, et al., 2004). Although it is acknowledged that there is a “constellation of factors” (Arseneault, et al., 2004) involved in the development of psychosis, research indicating the role that abstaining from substances can play in the prevention of psychosis simply cannot be disregarded in relation to a forensic psychiatric population. This might be regarded as accurate regarding both prevention and the possibility of rehabilitation.

Culture and cannabis use

While the relationship between poverty, race and class on mental health have been discussed in the literature review section, the issue of culture has not been overtly addressed within this research. Culture is mentioned specifically here as referring to the Generalisability of results from UK samples to South Africa. One study found that “despite differences in culture, context, and ethnicity, South African youth in the current study evidenced similar substance use initiation patterns to those documented in American research” (Patrick, et al., 2009). Unfortunately no studies investigating the generalizability of UK samples to South Africa could be found by the researcher, and it has been commented on that this is an area urgently requiring further research due to the many conditions unique to the South African context (Patrick, et al., 2009).

It has been noted that although historically the use of cannabis was a widespread and controlled Isi-Xhosa cultural tradition in South Africa, the context of modernisation and increasing urbanisation has contributed to the breakdown of traditional controls in relation to

its use (Peltzer & Ramlagan, 2007). This has resulted in increased patterns of cannabis usage by younger users and polyusers, without the traditional controls enforced historically (Peltzer & Ramlagan, 2007). While the relationship between culture and mental health is a pertinent issue, and one that certainly impacts on the way mental illness is viewed or constructed (Swartz, 1999); it is felt that it is beyond the scope of this research to explore this in too much detail. In addition, the research participants were not asked about their culture and thus it would not be appropriate to make inferences/assumptions on the part of the researcher in relation to this.

Life post FEH admission

Containment, boredom and relationships

Within a forensic psychiatric hospital, a balancing act is required between maintaining the safety of individuals and staff in the ward and creating a therapeutic environment (Muralidharan & Fenton, 2012). While the participants in this research largely described a containing ward environment, there were various incidents alluding to violence and inappropriate behaviour within the ward. In the account of one participant it appeared that contributing to his sense of containment within the hospital environment, was the perceived sense of threat from his environment outside the hospital. As a result of this sense of expected external pressure, he appeared to experience the hospital environment as an alternative safe space. While experiencing the hospital environment as containing is positive, within the larger presentation of successful rehabilitation as the ultimate goal, it is considered in this instance to be confounding.

Further research into external factors which contribute to diminishing chances of rehabilitation for forensic psychiatric patients is the lack of the necessary services to support them. While the provision of a containing space outside of the hospital is perhaps beyond the scope of the already-stressed psychiatric resources, further research into this area may be useful in contributing to external factors affecting the rehabilitation process. The emphasis that South Africa's Mental Health Care Act places on multiple levels of collaboration between professionals, community and individuals appears crucial in obtaining a larger and clearer picture of factors that impact on the successful rehabilitation of forensic psychiatric patients.

Factors contributing to uncontained behaviour appear to be influenced by a combination of matters relating to the individual patient, as well as to the staff and ward (Nijman, Merckelbach, Allertz & Campo, 1997). In respect of the ward environment, the requirements of structure, rules and routines are considered important within the context of inpatient settings (Bowers, 2009). Each of the participants was able to describe in detail their daily routines at the hospital, yet there appeared to be a fine line between a sense of comfort and boredom. Boredom was frequently mentioned by each participant throughout interviews, not just in relation to not having enough to do, but additionally, in finding the tasks/activities available to them unengaging. There appeared to be a sense of resignation (as differentiated from a sense of containment) with regard to the boredom experienced by participants within the ward. Further exploration of activities available to patients, along with possible new avenues of engagement, may prove beneficial in contributing to improve the forensic inpatient ward milieu.

As with ward routine and structures, the staff of a psychiatric ward is considered highly relevant to ward containment (Bowers, 2009). This was evident in the participant's accounts where they displayed an understanding of the boundaries in relation to the roles and functions of various staff, and how they felt in relation to these. Allusions were made to familiar psychiatric and psychological concepts such as unconditional positive regard (acceptance) and containment (calm, comfort) to doctors. It is interesting to note that these were also extended to the participant's experience of the students. Although the FEHBP will be discussed in detail further on in this section, it is pertinent to mention it briefly here due to it being considered an established activity, built upon relationships, that contributes to the ward milieu.

The importance that appeared to be placed on ward relationships by the participants is in line with literature on the topic. While practical factors (such as routine, food and activities) are acknowledged as contributors to the ward environment, research has shown that the contributing factor deemed most important by inpatients is that of social or person-to-person interaction (Thibeault, et al., 2010). In fact, research by Thibeault, et al. (2010) found that participants in their sample viewed relationships as synonymous with their environment (Thibeault, et al., 2010). As an alternate form of social or person-to-person interaction other than that provided by professional staff members, programmes such as the FEHBP under research in this work require further exploration to determine their potential in adding to a sense of containment to forensic psychiatric patients. Additionally, as there is much research

in support of the existence of an important link between the social atmosphere in a psychiatric unit and treatment outcome of the patient (Jansson & Eklund, 2002; Shiva, Haden and Brooks, 2009; Thibeault, et al., 2010); there may be scope for adaption or incorporation of similar FEHBPs into rehabilitation programmes. This is argued to be a viable suggestion from the perspective that incorporating non-professional, unpaid volunteers assists in lessening the weight of expectation placed on over-burdened staff and financial resources.

The FEH Buddy Programme

- *Relationships and Social Support*
- *Substitution*

Relationships and Social Support

Social relationships shown to be of value to an individual promote subjective well-being, as well as to reduce perceived levels of stress (Cohen, 2004; Ditzen, Schmidt, Strauss, Nater, Ehlert, Heinrichs, 2008). The element of individual perceived value and subjectivity is pertinent here. It has been shown that if the form of social support provided is not valued by the individual it is directed at, then social support can have a potentially negative effect (Hogan, Wolfgang & Bahman, 2002). This is despite general consensus for the overall protective factors and usefulness of social support interventions (Langford, et al., 1997; Wortman & Dunkel-Schetter, 1979).

The value that the participants placed on the FEHBP is understood in terms of the relationships they encountered and formed within it, and the nature of interaction within the space framed by the activities, rather than the activities themselves. Participants admitted to playing the major activity of the sessions (that is, card games) with other patients in the ward within their free time. However, ward time was largely referred to as being boring and dogged by anxious thoughts – in contrast to ‘fun’ and a ‘means of distraction from worries,’ which were used by participants to describe their experience of the FEHBP .

Protective factors

The material produced from this research suggests that the participants appeared to value their participation in the FEHBP and that they experienced first-hand protective factors associated with it. Their overall positive valuation of it was evidenced by several aspects.

Firstly, all of the participants had participated in the FEHBP for more than one consecutive year. The voluntary nature of participation implies that the patient's choice to continue was based on a perceived value of it. It was also inferred that the voluntary nature was in itself valued, with freedom of choice being linked to enjoyment. Secondly (and directly relating to protective factors as well) all of the participants described their experience of participation as providing them with a brief respite from the boredom and monotony of the wards; providing them with access to people from outside the hospital that they would not usually encounter; as temporary relief from worries or anxieties; and as a means to laugh and have fun. It is not possible to infer causality or the degree of well-being promoted from the FEHBP with this research. However based on the subjective, phenomenological reports of the participants, it is argued that their participation in the FEHBP appeared to provide them, by their own account, with perceived decreased stress levels and an increased (even if temporary) sense of subjective well-being. In other words, the protective factors of social support to which theorists refer to (Wortman & Dunkel-Schetter, 1979).

Social support

The degree to which Cobb's (1976, p. 300) definition of social support applies to the participant's overall experience of the FEHBP is debatable - ("information leading the subject to believe that he or she is loved, esteemed, and belongs to a network of mutual obligation"). The use of this definition in relation to its use with the casual nature and scope of the hourly, twice weekly meetings of the FEHBP might be criticised due to perhaps being considered as too strongly worded and over inclusive in relation to the participant's apparent experience of it. However, as the construct of social support is thought to consist of numerous fluid, interactive and interdependent components (Langford, et al., 1997), perhaps it is more useful to look at these components to shed further light on the experience of the participants involved in this research.

Social Climate

Theorists have asserted that the various components and theoretical foundations of social support cannot occur unless from within a "positive social climate of assistance and protection" (Langford, et al., 1997, 96). Social climate denotes the level of positive, protective and helpful factors associated with social support that is regarded as beneficial by the individual (Langford, et al., 1997). This definition of social climate appears to be in harmony with descriptions provided by the participants of their experiences with the students

during the FEHBP. Participants largely reported their experience as being protective, supportive and helpful. It is also worth noting that this description was not limited to the students, and was used to describe other relationships with other ward staff such as nurses, doctors and psychologists.

In line with existing research, the participants thus appeared to value their relationships with the students due to the varying degrees of “connectedness, engagement and affirmation” (Thibeault, et al., 2010, p. 226) that the activities provide them with. Furthermore, when participants’ rich, descriptive accounts of their interactions with the students, (that is, components of their relationships with them) are compared to the relatively sparse and much-less detailed accounts of the activities engaged in with them, it would seem that the person-to-person interaction described by Thibeault, et al. (2010) is supported in this research. Cassel’s (1976) concept of social embeddedness may also be considered applicable here. This term is used to refer to the level or degree of connectedness that an individual possesses in relation to significant others within their social network (Langford, et al., 1997).

Social embeddedness

Despite initial assertions that participants and the students ‘did not talk and just had fun’, accounts emerged of special relationships between participants and particular students - of jokes shared, of the participant feeling good in relation to a student due to either being able to teach them something, or to share in an activity such as dancing or singing with them, and lastly, from receiving praise from the students for something they did or achieved. This highlights the mutually rewarding element of reciprocity, which is generally agreed upon by theorists to form a substantial part of social support (Langford, et al., 1997). It also implies that there appeared to be a degree of social embeddedness in relation to the FEHBP and its network of student volunteers.

To add a further dimension to this, one of Seidman’s underlying phenomenologically-based presuppositions is that “people’s behaviour becomes meaningful and understandable when placed in the context of their lives and the lives of those around them” (Seidman, 1991, p. 10). The degree of apparent embeddedness with the students of the FEHBP needs to be understood within the context from which the participants, as well as that which they currently find themselves in. With regard to the past context, the background socio-economic section of this research detailed experiences largely illustrative of disenfranchisement, a lack of healthy support and a breakdown in family, community and formal structures. Within the

context of their current ward life, the sense of resignation to their dependent circumstances was felt, and although support was mentioned in relation to some staff relationships, it did not appear to emerge in relation to peers (each participant either described having no ward friends, or as only having a few). In addition, if there was lack of support prior to admission, this continued into the present and translated into difficulties for LOA's. Perhaps, then, the small window that the student FEHBP provides for social connection and support appears to be magnified within the context in which the participants reside, where there is relatively little support available outside of the limited range afforded by professional staff.

Buffering and main effects

In line with Cohen and Will's (1985) assertion that the buffering and main effects models are not necessarily mutually exclusive, material from this research provides some support for both. The sense of containment ascribed to the doctor's perceived ability to remain calm in the face of whatever difficulties are presented by the patients, relates to the protection afforded during stressful times as per the buffering model. The participants' comparison of the students to doctors, along with the inference that their relationship with them affords a sense of relief from anxiety, might be interpreted as further support for this model. On the other hand, the sense of apparent comfort and respite gained from the relationships formed within the FEHBP could also be explained using the main effects model, which posits that perceived social support has a direct bearing on an individual's sense of well-being and overall health. Although it was not possible from this research to assess the effects of the FEHBP on participants' well-being, from the participants' accounts it appeared that their subjective sense of well-being was increased as a result of their participation in the programme.

If the extent of integration into a large social network determines the degree of sustainment/maintenance of well-being (Cohen & Wills, 1985), perhaps the relatively short-term relief gained from the programme by the participants is accounted for by the limited size and variety of social networks available to them. In other words, it is not just the size of the social network, but also its variety/availability that is pertinent here. While there appeared to be some degree of embeddedness in the student/participant relationship, overall, the relationships available to the participants within the confines of institutional life appeared limited. Restricted social opportunities were perceived to be further magnified by the fractured social networks and apparently poor social support systems reported by the

participants in their lives external to the hospital environment. (This was apparent in discussions relating to the difficulties experienced with LOA.) Although the participants appeared to perceive some professional relationships (such as those with doctors and psychologists) as supportive and comforting, what cannot be ignored is the effect of the power imbalances at play within the professional/patient relationship (Peternelj-Taylor, 2005) on reciprocity and thus also on the degree of embeddedness within these relationships.

Thus, although the FEHBP may represent one potential avenue of strengthening social supports and widening the availability and variety of social networks available to participants, further options are required in order to extend, maximise and sustain the potential positive effects on the participants' sense of well-being. Once again, more research is required to explore other options in this area, as well as to investigate the possible effects of these activities/programmes on participants.

Reflection on social support in relation to IPA methodology

Lastly, due consideration must be given to the methodology used in this research. A key assumption of IPA is that the analyst wants to learn more about how a participant experiences a particular phenomenon (Smith, 2003) in order to contribute a new viewpoint or perspective to extant knowledge, or to identify areas for future research (Smith, 2004). Thus, while theories of social support may be useful in enlarging understanding of the participants' experience in some regards, only certain aspects appear fully to illuminate their experience. This highlights the need for further research in the area, in order to arrive at a more accountable and helpful way of shedding light on the experience of forensic psychiatric patients.

Substitution

Substitution for activities

Each of the participants made reference to the awareness that for them, the FEHBP functioned as a substitute for activities or pastimes which they used to engage in during their lives prior to admission. Examples provided by the participants included alcohol, drugs, and engagement with the opposite sex. This section will begin with what might be considered a surface level interpretation of substitution, before moving on to a deeper level of interpretation of the same concept in relation to theories of social support.

It appeared that the participants had used substances (particularly marijuana) during their lives prior to hospitalisation as a means to enjoy themselves, to relieve boredom, and to numb or escape from the worries and reality of their day-to-day lives. They described their experience of participation in the FEHBP as fulfilling the same purposes as the use of substances had fulfilled for them in the past. Similarly, since their involuntary hospitalisations, the participants all reported smoking cigarettes as a means of relieving the boredom they felt in the wards.

The participants made reference to tobacco smoking as being an 'acceptable' habit carried across from their lives prior to admission into the present. There were continual references to the significance of tobacco in relation to their ward lives, not just in terms of setting or punctuating the participant's routine as a relief from boredom, but additionally as a type of commodity capable of being swapped/bargained for with other patients. Interestingly, despite their reported dependence on nicotine, each participant reported either wanting to quit but being unable to do so, or remarked on the negative effects of tobacco smoking on their health. All of the participants reported not smoking nor having the urge to smoke during the hour of the student FEHBP. Additionally, they reported smoking tobacco as a way of soothing themselves and coping when they were disappointed by the cancellation of a session of the FEHBP.

The idea of substitution is considered pertinent here, in that – although for only two hours a week – the participants reported not having the urge to smoke tobacco due to having a more desirable alternative activity with which to replace smoking. The alternative activity fulfilled the functions of immediately relieving their sense of boredom, reducing anxiety, passing the time and, most important, being pleasurable – precisely the same purposes that smoking tobacco fulfilled for them. Of course, it would be a leap to suggest that the FEHBP in isolation could be a means to the cessation of smoking. However, it does seem reasonable to suggest that it functioned partly (albeit unintentionally) as a brief (although much healthier) alternative to smoking.

Further research into this idea may assist in determining whether the provision of an wider range of regular alternatives deemed to be of subjective value to participants (such as the FEHBP) might function as a more constructive means of boredom relief than smoking tobacco. It has been noted that in addition to taking a substantial toll on an individual's health, tobacco dependence literally comes at a high price due to the costs associated with the

medical care of forensic psychiatric patients falling under government responsibilities (Williams & Ziedonis, 2004).

Substitution or surrogate for social support

Another aspect of substitution relates more to social theories and the potential function of the FEHPB as a partial substitute, or perhaps even low level 'surrogate', for alternate avenues of support in a social form. The reciprocal nature of social support implies that a type of exchange must occur. Langford and colleagues (1997) maintain that in order for this exchange to take place, a degree of social competence must be present (Langford, et al., 1997). When one takes into consideration the backgrounds of the participants, the accounts which they provided were largely illustrative of challenging psychosocial conditions and poor social circumstances (apparently at least in part attributable to mental illness, crime and/or poverty). There was little mention of receiving or providing the reassurance and encouragement usually associated with social support networks (Langford et al., 1997), and thus, by implication, the levels of social competency present were minimal. This is of pertinence if one subscribes to social support theory, in terms of which the type of social network an individual has affects the potential level of their social competence, and thus possibly also their ability to participate in mutually beneficial social interactions (Langford et al., 1997).

The student/participant relationships in the FEHBP appeared to provide the participants with a supportive social network yielding certain protective factors that they deemed beneficial. In addition, there appeared to be a degree of social competence displayed through their open reciprocity and apparent sense of ease with the students. If social networks are considered the vehicle through which social support is provided (Langford et al., 1997), then the type of social network an individual has may impact on their potential level of social competence, and thus possibly also their ability to participate in mutually beneficial social interactions. Perhaps, then, in this context the FEHBP functions as a social network vehicle, opening or widening the potential for social support and thus the gap for mutually beneficial social engagement and a sense of social competence. More pertinently, and as will be elaborated on next, perhaps the FEHBP functions in this regard as a substitute or surrogate remedying a previous lack of social support.

The participants themselves acknowledged that the FEHBP functioned on some level as a substitute for activities which used previously to provide them with a sense of comfort. The

causal connection that is being argued, although not explicitly made by the participants, is that they may have engaged in activities such as substance use due to their not receiving, or not receiving enough of, the protective factors usually associated with the supportive network of a home environment. In other words, it appeared that the sense of relief gained from relationship with the students resulted from this being a substitute for what was itself a substitute (substance use) for positive experiences usually associated with functional social supports. By implication, then, and continuing with the analogy of FEHBP as a vehicle, perhaps the relationships within the programme can be considered as a type of learner vehicle or practice ground for social competency, compensating for the lack of access to such a training ground in the past.

Although considered beyond the scope of the present project, this idea might be worth further exploration, perhaps using object relations or systems psychology theories, to see whether the apparently positive social effects gained through the relationships in the programme are generalisable to relationships outside of it. Furthermore, the point that substitution in this instance takes place within the generally dichotomous agency-limiting yet sheltered confines of forensic institutional life would require additional consideration and exploration, particularly with regard to its application or extension to a context external to this, such as the home environment and rehabilitation.

Conclusion

The aim of this research was to explore the participants' subjective experience of the Fort England Hospital Buddy Programme (FEHBP), a social and activity-based, student-led initiative. Research into this programme (seen as an instance of non-professional support) sought also to explore more generally the value of such interventions within a forensic psychiatric context, and thus make a contribution to the literature pertaining to a neglected population segment (Baker, 2000). The use of Interpretative Phenomenological Analysis (Smith, 1996) as a methodology represents an attempt to legitimise the involvement of the patient in aspects of the ward milieu that have a direct bearing on their daily lives, and possibly even their treatment outcome (Jansson and Eklund, 2002).

The findings revealed apparent links between the poor psychosocial and socio-economic context of the participants prior to admission, and their current situations. This was particularly true with regard to parallels between challenges previously faced in their home environments and ongoing impediments to their rehabilitation processes. It appeared that, overall, the FEHBP was valued by the participants due to the capacity the reciprocal relationships formed within it had to provide them with a sense of fun or novelty, and relieve boredom and anxiety. These protective factors were seen as positively contributing to their social climate, whereas the sense of connectedness (Cassel, 1976) within the student/participant relationships was viewed as contributing to the social support structures available to the patients. However, it was recognised that the FEHBP served as only one additional link in the chain of possible social network opportunities available to the participants, and that a greater number of options and varieties was required for a more sustained sense of wellbeing to be fostered (Cohen & Wills, 1985). There was evidence to support both the main effects and buffering hypotheses regarding the links between social support and stress (Cohen & Wills, 1985).

The participants overtly acknowledged the role played by the FEHBP as a substitute for activities (such as alcohol abuse and the use of illegal substances) in which they engaged during their pre-admission lives for enjoyment as well as relief from circumstances they found either boring or anxiety-provoking. Tobacco smoking was acknowledged as a condoned carry-over from pre-admission and a continuing substitute for other activities

previously engaged in. The FEHBP itself appeared to function as a substitute, that is, as a temporary substitute for the habitual intake of nicotine.

On a deeper level, an hypothesis requiring further exploration is that the FEHBP, as an apparently positive additional link in the social network chain, appears to act as an educative process for increasing social competence, and thus may even act as a substitute for the lack of social support (and thus the opportunity to develop social competence) experienced in the pre-admission lives of the participants. In other words, the protective factors perceived as available through the use of harmful substances may have been sought because of the absence of protective factors to be gained from healthier or more traditionally functional alternatives, such as social support structures. It is thus possible that within institutional confines, the FEHBP may act in a substitutive capacity for harmful activities previously engaged in. Additionally, it may act in a surrogate capacity, as a practice space for the development of the social competence necessary for the reciprocity crucial to receiving the benefits associated with social support (Langford, et al., 1997).

However, it is not possible to make firm inferences or recommendations on the basis of these tentative interpretations, and further research (combining various methodologies) is required to ascertain the form, potential applicability, effects and usefulness of such interventions for a forensic psychiatric population. Additionally, idiosyncratic elements such as culture require further research consideration. While a considered strength of this research is its recognition of the importance of the role and voice of the psychiatric in-patient, and his or her ability to contribute to areas affecting his or her day-to-day life, a reflected weakness is the purely preliminary and exploratory nature of the enquiry. Extensive research is required in areas of psychiatric in-patient literature, and more specifically the forensic psychiatric sector, to meet the need for firmer and more reliable guidelines relating to rehabilitation (Bhana, et al., 2010). There is also increasing pressure to find multi-layered, collaborative ways of providing support to this sector, including involving non-professional support, due to the finite financial and professional resources available (Van Wyk, et al., 2010).

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Appendix 1 – Informed Consent

Rhodes University

Department of Psychology

Agreement between student researcher and research participant

I (participant's name) _____ agree to take part in the research project of (researcher's name) Jane Higgins on **Card games, roles and relationships: Psychiatric patient's experience of a student-led intervention.**

I understand that:

1. The researcher is a student doing this research as part of her course for a Master's degree at Rhodes University. The researcher may be contacted on 046 6038502 (psychology clinic) or J.Higgins@ru.ac.za. The research project has been approved by the relevant ethics committees, and the lecturer overseeing this research is Ms Ruby Patel in the Psychology Department at Rhodes University. She may be contacted on 046 6037212 (office) or R.Patel@ru.ac.za.
2. The researcher is interested in capturing the personal experience of the Fort England Hospital participants' involvement in the Rhodes University student-led programme.
3. My participation will involve 1-3 hour-long interviews (held over the period of 1 month during July 2012), where I will be asked about my experience of the programme.
4. I may be asked to answer questions of a personal nature, but I can choose not to answer any questions about aspects of my life which I do not want to share.
5. If I am worried, at any time, about anything relating to this research, I know that I can speak to the staff of Fort England Hospital, or to the researcher, or to Ms Ruby Patel – and they will be able to help me address my concerns or worries. I know that if I need emotional support, the psychologists and psychiatrists at Fort England Hospital will be available to help me.
6. I am free to stop taking part in this study at any time – however I commit myself to try participating in this study for the whole time it continues, unless something unusual happens or if I am worried for reasons that I didn't think have or think about at the beginning of the study.
7. The final report written by the researcher about this project may contain information about my personal experiences of, or attitudes towards the programme, but I know that general people reading the report will not be able to know that these are my experiences specifically; i.e. they will not be able to identify me.

Signed on (Date):

Participant: _____ Researcher: _____

Appendix 2 – Interview schedule (first set of interviews, 2012)

Interview schedule: patient’s experience of student-led initiative

Details and understanding of participation

1. How long have you taken part in the FEHBP for?
2. How often do you attend the weekly sessions?
3. What do you do in the FEHBP?
4. What made you first decide to take part?
5. If you had to tell a friend about the FEHBP, how would you describe it to them?
6. What was it about the FEHBP that made you want to continue taking part in it?
7. Can you tell me about a time when you thought about not taking part in the FEHBP?

RU student participants

1. What games or activities do you enjoy doing during the FEHBP?
2. Is there a particular person or group of ward friends that you prefer to play games with? (why ... can you tell me about what you do with this person or group of people ... how that makes you feel? *Prompt: physically, emotionally, mentally*)
3. Do you prefer to play games with one student group in particular, or are you comfortable to move around? ... (why?)
4. What it is like for you when new students arrive for the FEHBP at the beginning of each year?
5. Do you miss the students that used to be involved in the FEHBP?
6. Can you tell me about a particular student that you enjoy spending time with? ... (why... how does that make you feel? *Prompt: physically, emotionally, mentally*)
7. Can you tell me if there are any students that you would not like to play games with? ... (why ... how does that make you feel? *Prompt: physically, emotionally, mentally*)
8. How do you feel around the students? (*prompt: what do you think about?*)
9. Please tell me about any differences that you notice between the students and the ward staff such as nurses or psychologists?
10. Are there any students that remind you of anyone else in your life?

How the FEHBP is experienced

1. How do you feel after spending an hour playing games?
2. Are there any ways that you would like to change the FEHBP?
3. How does it make you feel when you are the winner of a game?
4. If you have lost a game, can you tell me about how you felt afterwards?
11. How do you feel when the FEHBP doesn’t happen, for example, during the holidays? (*Prompt: personal meaning/implications*)
5. Can you tell me about any memories that you may have of the FEHBP so far?
6. Can you think of any ways in which you think that the FEHBP might affect you?

Appendix 2 ctd

Identity and experiences of self

1. How would you describe yourself?
2. What do you tell new students involved in the FEHBP about yourself?
3. What do you tell new nursing sisters about yourself?
4. Can you think of any ways that you act differently during the FEHBP activities?
5. How does the FEHBP make you think or feel differently about yourself?
6. How does the FEHBP make you think differently about other people sharing your living space?
7. What meaning does taking part in the FEHBP have for you?

Appendix 3 – Interview schedule (second interviews, 2013)

Interview Schedule 2013

- I am interested to know a little more about you and what your life was like before your admission here. What was an average day like for you?
- What did you do from the time that you woke up until the time you went asleep?
- Who did you spend your time with?
- What was that like for you? (Supportive structures, family, friends, colleagues, professional)
- What activities did you used to spend your time doing?
-
- What did you do during the FEHBP?
- Can you give me details from the moment you arrived at the FEHBP to the time when the students left?
- What was that like for you?
- Who did you spend your time with, and why?
- What activities did you fill your time with?
- What about food? Can you tell me how that works in the FEHBP?

- How would you describe your relationship with the other patients/participants?
- ... nurses?
- ... security?
- ... psychologists?
- ... Doctors?
- ...students?

- Now that we have explored some of the relationships in your life, can you tell me how you think the students fit into this?

- Is there anything that you would like to add or ask?